89-1044

No. 89-

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Petitioner,

v.

BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

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QUESTIONS PRESENTED

1. Whether a jury is precluded as a matter of law from finding that a monopolist violated section 2 of the Sherman Act by reducing its payments to any supplier who persisted in marketing through an emerging competitor, when the effect of that conduct was to raise the costs and threaten the survival of the competitor and thus to raise the prices paid by consumers?

2. Whether the McCarran-Ferguson exemption for acts of coercion is to be narrowly construed to permit a monopolist to utilize a discriminatory pricing scheme to force customers to refrain from dealing with competitors?

3. Whether the McCarran-Ferguson Act should protect actions by an insurer which are initiated without the requisite state regulatory approval and, in any event, are not actively supervised by the state?

4. Whether a federal court may apply Sherman Act standards for exclusionary conduct in overturning a jury verdict based on the state tort of interference with contractual relationships?

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OPINIONS BELOW

The opinion of the Court of Appeals is reported at 883 F.2d 1101 and is reprinted in the Appendix hereto. The opinion of the district court granting judgment n.o.v. in favor of respondent is reported at 692 F. Supp. 52, and also is reprinted in the Appendix.

JURISDICTION

The judgment of the court of appeals was entered on August 21, 1989. A timely Motion for Rehearing With Suggestion for Rehearing *En Banc* was denied on September 25, 1989, and this petition for Writ of Certiorai was timely filed. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

Section 2 of the Sherman Act, 15 U.S.C. § 2, provides in pertinent part:

> Every person who shall monopolize, or attempt to monopolize . . . any part of the trade or commerce among the several States, . . . shall be deemed guilty of a felony. . .

Section 2 of the McCarran-Ferguson Act, 15 U.S.C. § 1012, provides in pertinent part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance. . . *Provided*, that after June 30, 1948, . . . the Sherman Act, and . . . the Clayton Act . . . shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Section 3 of the McCarran-Ferguson Act 15 U.S.C. § 1013, provides in pertinent part:

> Nothing contained in this chapter shall render the said Sherman Act inapplicable to any . . . act of boycott, coercion, or intimidation.

STATEMENT

1. Petitioner Ocean State Physicians Health Plan ("Ocean State") is a federally-qualified health maintenance organization ("HMO") licensed by the State of Rhode Island. (J.A. 7.)[1] Since 1983, Ocean State has offered health benefits on a prepayment basis to employer groups throughout the State. (J.A. 11, 60.) At the outset of the time period at issue in this case, Ocean State provided physician services to enrolled employees through contracts with approximately 1,200 physicians.[2] (J.A. 52.)

2. Respondent, Blue Cross and Blue Shield of Rhode Island ("Blue Cross") was created in 1982 by the merger of the then-separate Blue Cross and Blue Shield plans in Rhode Island. (J.A. 28.) Blue Cross is the dominant health insurer in Rhode Island, with a market

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[1] References in the Statement are to the Joint Appendix ("J.A.") and Plaintiffs' Exhibits ("P.E.") in the record on appeal.

[2] Ocean State Physicians Health Plan is a stock corporation, of which 80 percent of the shares are owned by Ocean State Coordinated Health Services Corporation. The remaining 20 percent of the shares are owned by United Healthcare, Inc. Petitioners Anthony J. Kazlauskas and Jeffrey C. Winters are members of a court-certified class of physicians who, during the time period at issue in this case, provided services to Ocean State and who also received reimbursement for their services from respondent, Blue Cross and Blue Shield of Rhode Island. (J.A. 2-3, 273; P.E. 425.)

share of at least 80%. (J.A. 266-68; P.E. 48-49, 56, 59.) Indeed, it is conceded in this case that Blue Cross has monopoly power. *See* 883 F.2d at 1110; 692 F. Supp. at 58. Blue Cross also is the largest marketer of physicians' services in Rhode Island, having participation contracts with nearly 2,000 physicians—more than 90% of those in the State. (J.A. 52, 318-20.) Blue Cross markets its health insurance to consumers and employers by emphasizing its broad panel of participating physicians. (P.E. 48, 49.)

3. This litigation arose from Petitioners' claims that, during 1986, Blue Cross engaged in an anticompetitive pattern of conduct intentionally designed both to raise Ocean State's costs by threatening its broad-based panel of contracting physicians, and to economically coerce employers to refrain from offering Ocean State as an alternative to Blue Cross. Those actions were asserted to violate Sections 1 and 2 of the Sherman Act, and the antitrust laws of the state of Rhode Island, as well as the state tort law prohibition against interference with contractual relationships, *i.e.*, between Ocean State and the members of the physician class. 692 F. Supp. at 54-55.

4. Typically, employers offered enrollment in Ocean State to each of their employees as an alternative to Blue Cross. *Blue Cross & Blue Shield of R.I. v. Cannon*, 589 F. Supp. 1483 (D.R.I. 1984). Following its entry into the market in 1984, Ocean State was able to grow from 12,000 members in December, 1984, to 87,000 members by the end of 1986, a 10% market share. (J.A. 78, 85-86, 89.) Approximately 75,000 of Ocean State members were former Blue Cross subscribers. (J.A. 57.) Indeed, since Ocean State's inception, Blue Cross regarded Ocean State as a special competitor because of its strong level of physician participation and support. (P.E. 65) Ocean State's success was, in fact, due in large measure to its 1,200 participating physicians, as well as its adoption of various cost containment strategies, including a program of utilization review and physician incentives. (J.A. 763,

806-07, 2167-69; P.E. 45.) Under Ocean State's program of physcian incentives, 20% of each physician's fees were "withheld" contingent on Ocean State's overall profitability. As a result of its innovative arrangements, Ocean State was able to offer a benefit package to consumers that was 15% broader than the Blue Cross package, at a price that was 5%-7% lower. (P.E. 45.)

5. Initially, Blue Cross attempted to respond to Ocean State's competitive challenge by keeping its premiums at bare-bones levels (J.A. 1249-50; P.E. 338), but this strategy was unsuccessful. During 1985, Blue Cross lost approximately $12.3 million on its group insurance business. (J.A. 1109.) During the first half of 1986, Blue Cross lost another $14 million on its group business, as well as a substantial number of subscribers. (J.A. 1110, 2017.) Facing the need for a substantial increase in premiums, which it feared would merely exacerbate the already clear trend toward enrollment in Ocean State, Blue Cross was forced either to improve the attractiveness of its own product or to attack Ocean State. It chose the latter course. Blue Cross' "formalized plan of attack" (J.A. 48; P.E. 416), against Ocean State ultimately included three distinct but related courses of conduct. (J.A. 334-35; P.E. 35, 638.)

a) *Adverse Selection Pricing.* Blue Cross undertook, without state approval (J.A. 1140.), a system of differential pricing under which employers offering competing health plans (including, in particular, Ocean State) were taxed with certain "adverse selection" factors, as a result of which those employers paid higher premiums than employers which offered only Blue Cross coverage to their employees. (J.A. 61-62, 518-25.) Those higher premiums in fact were arbitrarily derived and were not the product of legitimate actuarial determinations.[3] (J.A. 540-45, 1003-07, 1015-20, 1153-54; P.E. 343.)

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[3] The State ordered Blue Cross to cease using its Adverse Selection pricing until it obtained State approval for the rating formula. 692 F. Supp. at 59. Even after the State approved the formula,

b) *HealthMate.* Simultaneously, Blue Cross introduced an HMO "fighting ship" product called HealthMate. This product, which mimicked the Ocean State benefit package (J.A. 716-17; P.E. 293), was offered *only* to employers who also offered, or were known to be considering, the Ocean State plan,[4] and only as an alternative to traditional Blue Cross coverage, *i.e.*, rather than as a stand alone product.[5] (J.A. 59-60, 539-40, 831, 1091.) Blue Cross did not investigate the market attractiveness of HealthMate and did not consider HealthMate to be financially viable in the long term. (J.A. 719; P.E. 77.) Indeed, one Blue Cross executive recognized that if the plan was successful in attracting subscribers it would be an economic "disaster." (P.E. 353.) The more people that chose to participate in the program, the more money Blue Cross expected to lose. (J.A. 752-53, 1094.) The purpose of the product was to "save groups and increase enrollment." (P.E. 77.)

c) *Prudent Buyer.* Blue Cross also announced a policy under which it would not pay more for any physician's services than the physician was accepting from any competitor of Blue Cross. (P.E. 41, 113, 294.) Despite its facial neutrality, the policy was intended to penalize physicians who continued to contract with Ocean State

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Blue Cross was able to manipulate the resulting rates by overestimating the number and health status of its enrollees who would be lost to Ocean State. (J.A. 1137.) As a result, employers who offered Ocean State paid artificially high premium differentials. (J.A. 65-66, 553-59, 1104.)

[4] Thus, HealthMate was never offered to Blue Cross' own employees. (J.A. 1990.)

[5] Under Blue Cross' differential pricing scheme, employers who offered both HealthMate and Ocean State as an alternative to traditional Blue Cross coverage were quoted lower rates than those who offered only Ocean State as an alternative—but not as low as the rates they would receive if they offered only traditional Blue Cross. (J.A. 61-62, 587-88.)

by reducing payments to those physicians by 20%.[6] (J.A. 845-46.) As one Blue Cross executive wrote in an internal memorandum, "not one guy in the state isn't going to know the implication of signing with Ocean State." (P.E. 38.) Physicians who did not contract with Ocean State, or who dropped their Ocean State contracts, were paid their full Blue Cross rates.

During the initial phase of Prudent Buyer, physicians who did not pledge, by September 15, 1986, that Blue Cross payment amounts were the lowest they would accept were subjected to a 20% reduction in their Blue Cross payment rates. (J.A. 29, 840, 1238-39.) The 20% figure was chosen because, at that time, it represented the amount Ocean State withheld from its participating physicians as a cost containment incentive (J.A. 29.) That amount, however, did not necessarily represent a discount because Ocean State could, and sometimes did, return all or part of the "withhold" amount depending on the year's profitability. (J.A. 227, 783-84, 874-48.)

In order to give Ocean State physicians time to resign from Ocean State, Blue Cross changed the implementation date of the Prudent Buyer policy and undertook an effort to inform physicians of the Ocean State contract termination date. (P.E. 45, 294, 344; J.A. 852-55, 1220-22, 1227-31.)[7] Moreover, Blue Cross even "grandfathered" some physicians who missed the Ocean State contractual cut-off date if those physicians pledged that they would drop out of Ocean State the following year. (J.A. 1208-09.)

In the second phase of Prudent Buyer, Blue Cross abandoned any pretense of seeking only "most favored"

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[6] In fact, the 20% payment reduction was applied only to Ocean State physicians. (J.A. 779, 845-46.) Blue Cross made no effort to determine whether any insurer other than Ocean State obtained any discount from physicians. (J.A. 780.)

[7] Failure to notify Ocean State of termination 90 days before the termination date required the physicians to continue their Ocean State contracts for an additional year. (J.A. 854, 861, 1208-19.)

rates and simply reduced the fee profile of those physicians who continued to contract with Ocean State by 20%, without regard to the actual amount paid by Ocean State. (J.A. 225-29, 780-84.)

Cost-savings were not the motivation for Prudent Buyer, as Blue Cross' witnesses conceded at trial. (J.A. 850.) Blue Cross made no initial estimates of any savings that were to be achieved (J.A. 336-37, 850-51) and actual savings proved to be extremely small, approximately one-half of one percent of Blue Cross' total private health insurance payments. (J.A. 1232; P.E. 640.) What Blue Cross *did* estimate was the cost advantage enjoyed by Ocean State by virtue of its physician "withhold" arrangement—i.e., $1.4 million. (J.A. 336-39; P.E. 45.) When asked to explain why Blue Cross estimated Ocean State's savings rather than their own, Blue Cross' Chairman of the Board of Directors offered no answer. (J.A. 339.) Yet, Blue Cross' own documents clearly indicate the reason: Blue Cross didn't have the luxury of waiting another year for Ocean State's physicians to resign. (P.E. 45.)

6. Following the 1986 implementation of Blue Cross' tripartite strategy, Ocean State experienced the defection of approximately one-third of its physicians. (J.A. 52, 158, 636-37.) Concomitantly, Ocean State incurred approximately $2 million in additional costs to replace the services of the defecting physicians and to strengthen its marketing. (J.A. 154-55, 168-69, 181-82, 255-56, 1443.) Ocean State's enrollment ceased to grow and it lost the business of some employers. (J.A. 65, 163-66, 585-89, 1256-57, 1268, 1426-28; P.E. 739-741, 771-772, 775.)

7. As Ocean State's induced reverses were realized, Blue Cross' financial situation improved markedly. During the six-month period beginning in September 1986, Blue Cross recorded nearly $10 million in surplus. (J.A. 1111.) That turnaround resulted largely from the imposition of profitable increases in premium levels, as Blue Cross' experts conceded at trial. (J.A. 1110-13, 1847-49, 2183-84.)

8. This litigation was commenced by Ocean State on Sept. 30, 1986, alleging that Blue Cross' conduct constituted a violation of Sections 1 and 2 of the Sherman Act, as well as state antitrust laws and the state common law prohibition on tortious interference with contractual relationships. The jurisdiction of the district court was invoked under 15 U.S.C. § 15 and 28 U.S.C. § 1331.

9. At the close of the petitioners' case, the district court granted Blue Cross' motion for a directed verdict as to the Section 1 claim. (J.A. 1550.) The Sherman Act Section 2 claim and the tort claim were submitted to the jury, which returned a verdict finding the defendant, Blue Cross, "guilty" on both the Section 2 and tortious interference claims. After twice returning an award of damages undifferentiated as to the separate claims, the jury was instructed by the district court that damages could be awarded only once. The jury then maintained its liability finding on both claims, but attributed the monetary damages to the tort claim.[8]

10. Petitioners thereupon sought entry of an injunction pursuant to Section 16 of the Clayton Act, 15 U.S.C. § 26, and requested additur on the antitrust claim, while Blue Cross moved for judgment notwithstanding the verdict on both claims and, alternatively, for a new trial on the tort claim alone. By opinion and order dated July 27, 1988, and July 28, 1988, respectively, the district court granted the motion of Blue Cross for j.n.o.v. and denied petitioner's motions. The district court conceded that Blue Cross "clearly had market power." 692 F. Supp. at 58. However, the court held that Ocean State and the physician class had failed to establish causation by virtue of the jury's failure to award damages on the Section 2 claim. The court additionally held that, in any

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[8] On the tortious interference count, the jury awarded Ocean State $947,000 in compensatory and $250,000 in puntive damages, and awarded the physician class compensatory damages of $1,746,437. (J.A. 31-32; 692 F. Supp. at 55-56.)

event, Blue Cross' Adverse Selection, HealthMate, and Prudent Buyer strategies did not violate Section 2, notwithstanding the jury verdict, because each element of Blue Cross strategy could be explained as "justified responses to competitive conditions." 692 F. Supp. at 73. In so doing, the district court determined that the existence of market power does not prohibit a monopolist from undertaking conduct that could lawfully be undertaken by a firm without market power. 692 F. Supp. at 71.

11. Finally, the court held that Blue Cross' conduct did not constitute tortious interference with Ocean State's physician contracts because it deemed the physician defection from Ocean State to be the result of the individual decisions of the participating physicians and, in any event, it deemed Blue Cross' actions to be legitimate under the same analysis used with respect to the Sherman Act claim.

12. The court of appeals affirmed on somewhat different grounds. Specifically, the court of appeals declined to adopt the district court's view that the jury's failure to award damages precluded a finding of antitrust liability, noting *inter alia* the jury's apparent difficulty in allocating damages between the antitrust and tort claims, as well as the lack of clarity in the district court's instructions on this point. 883 F.2d at 1106-07 n.5. The court then determined that Petitioners' Section 2 challenge, insofar as it related to the HealthMate and Adverse Selection policies, was barred by the McCarran-Ferguson Act, notwithstanding the fact that Blue Cross did not raise the McCarran defense with regard to HealthMate. 883 F.2d at 1107 n.6. Although noting that Rhode Island's regulation of those activities lacked specificity, the court held that specific supervision was not required and the existence of a general regulatory scheme was sufficient to invoke the McCarran-Ferguson exemption. 883 F.2d at 1108-09. The court also summarily determined that Blue Cross' use of Adverse Selection to force employers to drop Ocean State did not constitute "coercion" within the

meaning of the exception to the McCarran-Ferguson exemption. 883 F.2d at 1109.

13. Recognizing that Prudent Buyer did not qualify for McCarran-Ferguson protection as the "business of insurance," the circuit court conceded that the trial court erred in failing to recognize that the same conduct which might be harmless when undertaken by an actor without market power can be unlawful when undertaken by a monopolist, such as Blue Cross. 883 F.2d at 1110. The court also conceded that a jury could have found that Blue Cross' conduct was designed to eliminate Ocean State as a competitor. 883 F.2d at 1113. Nonetheless, the court ruled, as a matter of law, that the Prudent Buyer policy was not exclusionary. Relying on *Kartell v. Blue Shield of Mass.*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985), the court held that, notwithstanding the jury verdict, Prudent Buyer must be characterized as a purchaser's effort to obtain the best possible price. 883 F.2d at 1112-13. The court stated that "a policy in insisting on a supplier's lowest price—assuming that the price is not 'predatory' or below the supplier's incremental cost—tends to further competition and, *as a matter of law*, is not exclusionary." 883 F.2d at 1110 (emphasis added).

14. The Court of Appeals also held that Prudent Buyer did not constitute tortious interference with Ocean State's physician contracts "for essentially the same reasons" that it deemed the conduct not violative of the Sherman Act, *i.e.*, that it constituted "legitimate competitive activity." 883 F.2d at 1114.

SUMMARY

This case presents an opportunity for this Court to correct legal errors of potentially far-reaching consequence for the administration of Section 2 of the Sherman Act. The Court of Appeals below enunciated a rule of *per se* legality that, if generally adopted, would shield all exclusionary practices for which a defendant monopolist could proffer any colorable efficiency justification.

Disregarding the jury's verdict that Blue Cross was "guilty" of monopolization the First Circuit held that the conduct at issue was not exclusionary as a matter of law, even though respondent's monopoly power was not questioned; the court acknowledged that respondent may have intended to use its monopoly power to destroy its only effective competitor; and the jury legitimately could have found that respondent exercised that power to the detriment of consumers. It would be difficult to imagine a holding more directly at odds with, and posing a greater threat to, appropriate standards of liability under Section 2 of the Sherman Act.

In the 23 years since the decision in *United States v. Grinnell Corp.*, 384 U.S. 563 (1966), this court has reviewed only two Section 2 cases: *Otter Tail Power Corp. v. United States*, 410 U.S. 366 (1973), and, *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985). Moreover, only *Aspen Skiing* has been decided since this Court began to enunciate an approach to antitrust jurisprudence which inquires more closely into the existence of economic efficiency and harm to consumers.[9]

The court of appeals misconstrued *Aspen Skiing* in two ways. First, it read this Court's holding to require the question of liability to be determined as a matter of law, rather than on the factual record as a whole. It then adopted a rationality test of monopoly conduct, under which conduct explainable as furthering an efficiency interest cannot be exclusionary, regardless of the actual purpose of the conduct, or its potential for harm to consumers.

The protectiveness manifested by the court of appeals towards the monopolist in this case may be understood as a misguided attempt to employ this Court's modern

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[9] This focus is evident in *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979); *NCAA v. Board of Regents*, 468 U.S. 85 (1984); *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284 (1985); and *Cargill, Inc. v. Monfort of Colorado, Inc.*, 479 U.S. 104 (1986).

approach to antitrust analysis. Yet, the opinion below clearly tips the balance too far in favor of any proffered efficiency justification, at the expense of the jury's inquiry into the actual nature and effect of the conduct at issue.

The court of appeals also misappropriated principles used in "predatory pricing" analysis.[10] 883 F.2d at 1110. Strategic behavior by a monopolist—increasingly referred to as "non-price predation"—is different in character from "predatory pricing." Krattenmaker and Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power Over Price*, 96 Yale L.J. 209, 224 (1986). Strategies like that employed by Blue Cross in this case are clearly more plausible, less expensive to initiate, and potentially successful even if the competitor does not exit the market. Krattenmaker and Salop, *Analyzing Anticompetitive Exclusion*, 56 Antitrust L.J. 71 (1987). *Compare Cargill*, 479 U.S. at 119 n.15, 121 n.17.

The decision below thus illustrates what has been described as the "substantial disarray" in antitrust law governing exclusionary conduct, reflecting a conflict between prevailing doctrine and "pleas for laissez-faire rules" of *per se* legality.[11] Krattenmaker and Salop, *Ana-*

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[10] Even with respect to "predatory pricing," there is a significant split in the circuits regarding the appropriate standard for "exclusionary" conduct. *See Cargill*, 479 U.S. at 117 n.12; *A.A. Poultry Farms, Inc. v. Rose Acre Farms, Inc.*, 881 F.2d 1396 (7th Cir. 1989).

[11] For example, some courts have stated that unlawful monopolization can be established whenever a defendant with monopoly power specifically intends to monopolize, even in the absence of anticompetitive effects. *Paschall v. Kansas City Star Co.*, 727 F.2d 692, 696 (8th Cir.), *cert. denied*, 469 U.S. 872 (1984). *See also MCI Communications v. American Tel. & Tel. Co.*, 708 F.2d 1081, 1148 (7th Cir.), *cert. denied*, 464 U.S. 891 (1983). In contrast, some courts have stated "what should matter is not the monopolist's state of mind, but the overall impact of the monopolist's practice." *Byars v. Bluff City News Co.*, 609 F.2d 843, 860 (6th Cir. 1979). Indeed, the same circuit court has enunciated inconsistent standards. *Compare Paschall with Trace X Chemical, Inc. v. Canadian*

lyzing Anticompetitive Exclusion at 89-90. This "disarray" is particularly apparent with regard to the analysis of health insurers' exclusionary conduct. *Compare Ocean State with Reazin v. Blue Cross and Blue Shield of Kansas, Inc.*, 663 F. Supp. 1360, 1418 (D. Kan. 1987) (appeal pending) (describing Blue Cross plan's "most favored nations" clause in provider contracts as furthering Blue Cross' ability to control insurance prices). The court of appeals' decision should be reversed, not only to encourage active competition in the economically significant health insurance and physician services markets, but, more importantly to reaffirm the basic principles of antitrust law embodied in *Grinnell* and *Aspen Skiing*, and to enunciate the appropriate legal standard for non-price predation involving conduct designed to raise rivals' costs. *See* Baker, *Vertical Restraints Among Hospitals, Physicians and Health Insurers That Raise Rivals' Costs*, 14 Am. J. Law & Med. 147, 150-51, 161-62 (1988).[12]

This case also raises important legal questions concerning the appropriate scope of the McCarran-Ferguson exemption to the antitrust laws. Specifically, this case provides an opportunity for this Court, for the first time, to define "coercion" in the context of the statutory exception to the McCarran-Ferguson shield for the "business of insurance". Moreover, this case also provides an opportunity to address the breadth of the McCarran-Ferguson exemption itself, as it applies to insurer's conduct that is unsupervised by the states. Lower court decisions since the 1940's, including the decision below, have taken an increasingly broad view of the "regulated by state law" aspect of the exemption, which is plainly inconsistent with this Court's recent pronouncements that

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Industries, Ltd. C.I.L., 738 F.2d 261, 268 (8th Cir. 1984), *cert. denied*, 469 U.S. 1160 (1985).

[12] *See also* Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 Law & Contemporary Problems 195 (1988); Stenger, *Most-Favored-Nation Clauses and Monopsonistic Power: An Unhealthy Mix?*, 15 Am. J. Law & Med. 111 (1989).

the McCarran exemption should be narrowly construed. Finally, this case presents the opportunity for this Court, for the first time, to determine whether federal courts may apply Sherman Act standards in determining liability under state tort law.

REASONS FOR GRANTING THE PETITION

I. THE COURT OF APPEALS' DECISION CREATES A SPECIAL RULE OF PER SE LEGALITY FOR NON-PRICE PREDATION IN DEROGATION OF APPROPRIATE SECTION 2 JURISPRUDENCE

The jury's verdict in favor of Ocean State was rendered pursuant to instructions which reflect the settled and well-understood precepts of Section 2 liability: possession of monopoly power, the willful maintenance of that power through restrictive or exclusionary conduct, and injury to competition. *Grinnell*, 384 U.S. at 570-71.[13]

The court of appeals deprived Ocean State of its jury verdict on the theory that conceded monopoly power cannot have been exercised unlawfully if the defendant can offer any purported efficiency justification for its conduct. Far from ensuring that aggressive competition is protected from inappropriate condemnation as a restraint of trade, the First Circuit's special rule further insulates the exclusionary conduct of a monopolist—in this case, conduct designed to raise rivals' costs—from antitrust scrutiny.

A. The Court of Appeals Erred in Applying to Non-price Predation Concepts Borrowed from the Law of Predatory Pricing

In analyzing the merits of Blue Cross' Prudent Buyer program, the Court of Appeals inappropriately borrowed from the emerging law governing predatory pricing.

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[13] Monopoly power includes the power to exclude competition. *United States v. E.I. DuPont de Nemours & Co.*, 351 U.S. 377, 389, 391 (1956); *Cleveland v. Cleveland Elec. Illuminating Co.*, 734 F.2d 1157, 1168 (6th Cir.), *cert. denied*, 469 U.S. 884 (1984).

Although the alleged exclusionary practice did involve prices—specifically, a monopolist's use of price-setting power to induce its suppliers to deal exclusively with it—the scheme can be seen as a classic instance of "raising rivals' costs", a form of non-price predation. This conduct bears only a very distant kinship to predatory pricing.

The court of appeals concluded that the lower reimbursement levels which Blue Cross imposed could not be exclusionary unless they were below the suppliers' incremental costs. 883 F.2d at 1110. Such a cost-based test may be helpful in predatory pricing cases as a way of distinguishing competitive pricing based on efficiency from conduct which involves accepting short-run losses in anticipation of their recoupment once the competitors are destroyed. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 584 n.8 (1986); *Cargill*, 479 U.S. at 117-18. In this case, however, the relationship between the *suppliers'* prices and their costs sheds little light on the *buyer's* purposes or the impact of its conduct on consumers. *See* Miller, *Vertical Restraints and Powerful Health Insurers* at 233-35.

This Court has noted that claims of predatory pricing are highly speculative or conjectural. *Matsushita*, 475 U.S. at 587-88. But exclusion by raising rivals' costs is a less conjectural strategy for a firm with market power. Cost-raising strategies do not require the sacrifice of short run profits, nor the competitor's exit from the market. The impact on the competitor's output is immediate and disproportionate. *See* Krattenmaker & Salop, *Analyzing Anticompetitive Exclusion* at 73. Thus, conclusive presumptions of legality are far more likely to shield exclusionary conduct in cases of non-price predation designed to raise rivals' costs.

B. A Merely Colorable Business Justification for Conduct Alleged to be Exclusionary has Never Been Deemed a Sufficient Defense for Non-price Predation Under Section 2

While the absence of any business justification for certain conduct is probative of an exclusionary purpose (and thus of the prohibited monopolistic effect), the mere proffer of an efficiency rationale has never been held by this Court to immunize a monopolist's conduct. Even behavior that might improve efficiency nonetheless may be deemed exclusionary if its benefits are only incidental in comparison to its anticompetitive effects. *In re E.I. DuPont de NeMours & Co.*, [1979-83 Transfer Binder] Trade Reg. Rep. (CCH) ¶ 21,770 at 21,960, 21,982 n.38 (1980). As the FTC recognized in *Dupont*, there is a danger in focusing only on efficiencies—the benefit side of the equation—to the exclusion of possibly destructive effects on competition.

> [T]he actions of the would-be monopolist may enhance efficiency or product performance, albeit marginally, although the overall competitive effect is decidedly negative . . . Moreover, behavior that is rational for a firm with little or no market power may nevertheless produce substantial and unnecessary anticompetitive effects when wielded by a firm with considerable market clout.

In re DuPont at 21,978. *See also Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 274-75 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980) (unlawful use of monopoly power may be shown by conduct dependent on monopoly power for success); *Telex Corp. v. IBM*, 510 F.2d 894 (10th Cir.), *cert. dism'd*, 423 U.S. 802 (1975).

Thus, the role of the fact finder to weigh the putative efficiencies and competitive benefits of challenged conduct against the alleged exclusionary characteristics and effects of that conduct is paramount. *See Greyhound Computer Corp. v. IBM Corp.*, 559 F.2d 488 (9th Cir. 1977), *cert. denied*, 434 U.S. 1040 (1978); *Transamerica Com-*

puter Co. v. IBM Corp., 481 F. Supp. 965 (N.D. Cal. 1979). The danger of condemning conduct that is actually beneficial to consumers is controlled in such cases, as in all Sherman Act cases, by the requirement of proving antitrust injury.

The court of appeals believed its analysis to be compelled by this Court's reasoning in *Aspen Skiing*. But the issue in *Aspen Skiing* was not simply the petitioner's conceded lack of business justification for its conduct; it was, instead, whether the evidence as whole was sufficient to support the jury's verdict in favor of the respondent. 472 U.S. at 599, 610-11. Indeed, the Court's statement that the jury's verdict was "strongly supported by Ski Co.'s failure to offer any efficiency justification whatever for its . . . conduct", *id.* at 608, implied that, if such a showing had been made, it would have been for the jury to evaluate. Nowhere did the Court suggest that any colorable justification would have preempted all of the plaintiff's evidence.[14] What this Court did recognize was the importance of harm to consumers. *Id.* at 606.

C. The Court of Appeals Failed to Recognize as a Factual Matter, and thus Immunized as a Matter of Law, a Classic Instance of Non-price Predation, by which a Monopolist Raised its Rivals' Costs, Entrenched its Position as the Dominant Marketer of Physician Services, and Raised the Cost of Health Care and Health Insurance

The health care industry historically has been marked by a lack of price competition in both the financing and delivery of health services. Miller, *Vertical Restraints*

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[14] Similarly, it cannot be seriously contended that this Court's finding of attempted monopolization in *Lorain Journal Co. v. United States*, 342 U.S. 143 (1951), would have been different if the defendant newspaper had asserted that its new policy would induce some advertisers to place all of their ads with it, thus offsetting the revenue it could expect to lose from those who chose to patronize the radio station exclusively.

and Powerful Health Insurers at 195. In many states, including Rhode Island, nonprofit health service plans (*i.e.*, Blue Cross and Blue Shield plans) have garnered a dominant position in the health financing market, attributable, *inter alia*, to their provider-controlled origins, tax and regulatory advantages, and direct contractual relationships with physicians and hospitals. Baker, *Vertical Restraints Among Hospitals, Physicians and Health Insurers* at 148-49. Effective competition with these plans is a recent phenomenon, largely attributable to the growth of integrated financing and delivery arrangements, such as health maintenance organizations, *e.g.*, Ocean State. Miller, *Vertical Restraints and Powerful Health Insurers* at 200-04. Indeed, it has been suggested that HMOs represent the only viable competitive threat to entrenched Blue Cross plans. *Reazin*, 663 F. Supp. at 1417.

HMO competition has been encouraged, in part, because of the enormous economic significance of the health care financing industry.[15] HMOs compete by creating incentives for providers to practice cost-effective medicine. Those incentives (in this case, the Ocean State "withhold") are the core of Blue Cross' attack on Ocean State. Far from reducing costs to consumers, Blue Cross' strategy allowed it to raise Ocean State's costs, suppress competition among physicians, and raise prices to consumers, or so the trier of fact should have been permitted to determine.

Historically, direct-contracting insurers (predominantly Blue Cross/Blue Shield plans) have fulfilled their role as a "purchaser" (or, more accurately, as a "broker" or "marketer") of provider services in one of two ways. Such plans may act to buy services on behalf of their subscribers or they may act to sell services on behalf of

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[15] Total 1987 expenditures for private health insurance exceeded $157 billion. Levit, Freedland, and Waldo, *Health Spending and Ability to Pay: Business, Individuals and Government*, 10 Health Care Financing Review 1 (Spring 1989).

their contracting providers.[16] The dichotomy between the role of joint selling agent and the role of joint purchasing agent was identified succinctly by the Seventh Circuit in *Ball Memorial Hospital v. Mutual Hospital Ins. Co.*, 784 F.2d 1325 (7th Cir. 1986). That case addressed the propriety of a dominant Blue Cross plan's decision to implement a so-called "preferred provider" system of selective contracting with hospitals based on competitive bidding. The court, in upholding the plan's actions as a legitimate purchasing arrangement on behalf of the plan subscribers, specifically quoted an internal policy document of the Indiana Blue Cross plan recommending that the plan, for the first time, "use its market position . . . to negotiate lower fees for provider services." *Id.* at 1337-38. That decision was a considered response to competitive pressures in the Indiana health insurance market. *Id.* at 1332.

Likewise, in *Kartell*, the First Circuit correctly charterized the Massachusetts Blue Shield plan's ban on "balance billing", which applied uniformly to all participating physicians *and* which resulted in lower charges to the plan's subscribers, as a legitimate action to obtain the best prices for physician services. Significantly, there was no evidence in *Kartell* that price competition in the

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[16] Although many courts have assumed the former characterization to be true, the latter role—as a concerted selling agency—historically was predominant. "Blue" plans originally were governed by their participating providers. Even after provider control of such plans passed from prevalence, it remained in the plans' interests to continue as the providers' joint selling agents. That is, having gained significant market share through historical tax and regulatory advantages, as well as their direct contracting relationships with providers, such plans evidenced a willingness to share monoply profits with providers in order the maintain their provider networks and hence, their market shares. As regulated non-profit entities, the "Blue" plans historically faced lesser incentives to maximize "pure" profits and greater incentives to maximize total revenue and market share. *See* Havighurst, *The Questionable Cost Containment Record of Commercial Health Insurers* in Health Care in America 221, 248-51 (Frech, ed. 1988).

physician services market was restricted by the Blue Shield's payment practice.

In uncritically characterizing the Rhode Island Blue Cross plan as a "purchaser" of health services, the court below failed to recognize the adverse effect which Prudent Buyer had on consumers by stifling price competition in the physician services market, which in turn permitted Blue Cross to profitably raise prices in the health insurance market. The court flatly rejected the possibility that Blue Cross used its monopoly power to preclude competition by forcing its contracting physicians to cease dealing with Blue Cross' competitor, unless that competitor increased its payments to physicians. 883 F.2d at 1113 n.12.

It cannot be assumed that Blue Cross' control of the physician services market is benign simply because Blue Cross has some attributes of a "buyer." Where an insurer has market power in *both* the sale of insurance and the purchase of provider services, the potential for improper use of market power is great. Miller, *Vertical Restraints and Powerful Health Insurers* at 207. The fact that Blue Cross is an economic force in the physician services market, of course, is directly attributable to its monopoly in the health insurance market. Its position as a monopoly broker of physician services, in turn, preserves its health insurance monopoly by allowing it to drive up its competitors' costs. Thus, consumers are injured as clearly by reduced competition in the marketing of physician services as they are by reduced competition in the marketing of health plans.[17] The Court of Appeals' failure to consider, let alone appreciate, the interrelated effects of Blue Cross' dual monopoly power has given

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[17] "The exercise of market power . . . does not require that a firm also have the ability to raise price by restricting its own output unilaterally. A firm also can exercise market power by raising competitors' costs and thereby inducing them to restrict their production or exit, which causes the market price of their output to raise." Krattenmaker & Salop, *Analyzing Anticompetitive Exclusion* at 79.

Blue Cross, and monopoly insurers generally, an enormous and inappropriate shield against Section 2 claims.[18]

There was ample evidence in this case from which the jury could, and did, conclude that Blue Cross' purported business justifications were marginal rationalizations of otherwise exclusionary conduct. Indeed, Blue Cross conceded that Prudent Buyer was not motivated by concern for cost savings, and the savings achieved through Prudent Buyer were minimal—less than one half of one percent of total expenditures. Moreover, the evidence showed that Prudent Buyer was imposed only against physicians contracting with Ocean State and not those selling their services through any other health plan.

Further, Blue Cross actually attempted to *minimize* its cost savings. Specifically, it encouraged physicians to avoid the impact of Prudent Buyer by terminating their relationships with Ocean State, and purposefully extended the time in which physicians were permitted to make that decision. In other words, the Prudent Buyer program was equally, and indeed more rationally, capable of being viewed as an offer to continue to *pay more* to physicians who agreed not to deal with Ocean State rather than an attempt to pay less for physician services

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[18] Similarly, in *Travelers Ins. Co. v. Blue Cross of Western Pa.*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973), a case also relied upon by the Circuit Court, the Third Circuit made a comparable error in analysis in concluding that Blue Cross of Pennsylvania was merely engaged in "hard bargaining". The evidence recited in the Third Circuit's opinion in *Travelers* hardly permits any other interpretation than that the Blue Cross plan, instead of exerting its market power against the hospitals as a true "Prudent Buyer" seeking to get maximum discounts, elected to accept a lesser discount negotiated with the state hospital association and to count on the hospitals collectively to see that its competitors got no discounts at all. Professors Krattenmaker and Salop have observed that cultivating a cartel of suppliers with which one's competitors must contend is an excellent strategy for "raising rivals' costs." The *Travelers* case is a classic instance of this kind of exclusionary conduct. *See* Havighurst, *The Questionable Cost-Containment Record of Commercial Health Insurers* at 248-54. Regrettably, the *Travelers* court did not recognize it as such.

generally. This evidence alone speaks volumes in rebuttal to any putative efficiency justification.

Finally, the evidence showed not only that Ocean State's costs were increased as a direct result of this conduct, but that Blue Cross was able to increase its prices and profits. Consumers did not benefit from the alleged "efficiencies." This evidence, likewise, is to be ignored under the First Circuit's special rule, notwithstanding that it goes to the essence of antitrust injury. 883 F.2d at 1111 n.11.

Clearly, the court below has distorted the basic principles of Section 2 jurisprudence. Absent clarification, monopoly buyers in general and monopoly health insurers in particular are effectively unfettered by Section 2.

II. THE DECISION BELOW EXTENDS THE REACH OF THE McCARRAN-FERGUSON EXEMPTION TOO BROADLY

A. The McCarran-Ferguson Act Should Not Be Interpreted to Preclude Consideration of Exempt Conduct That Is Intertwined With Non-Exempt Conduct

The court of appeals' failure to identify the exclusionary nature of Prudent Buyer is magnified by its refusal to examine the relevance of the other two-thirds of Blue Cross' strategic behavior. Under the antitrust laws, the character and effect of challenged conduct is not to be judged "by dismembering it and viewing its separate parts, but only by looking at it as a whole." *United States v. Patten*, 226 U.S. 525, 544 (1913). *See also Continental Ore Co. v. Union Carbide & Carbon Corp.*, 370 U.S. 690, 699 (1962); *Aspen Skiing*, 472 U.S. at 599, 610-11.

The Ocean State look-alike product, HealthMate, and the discriminatory pricing mechanism, Adverse Selection, were integral to the overall success of Blue Cross' design to eliminate Ocean State as a competitor. The court of appeals surgically separated the three aspects of Blue Cross' strategy and determined that HealthMate and

Adverse Selection fell within the "business of insurance" exemption of the McCarran-Ferguson Act. On that basis, it declined to consider their import further in regard to Blue Cross' conduct. In so doing, the court interpreted McCarran-Ferguson not only to bar consideration of those elements by the fact-finder in evaluating the legitimacy of the non-exempt Prudent Buyer strategy, but also to bar their consideration by the *court* in determining whether Blue Cross' conduct as to Prudent Buyer had to be characterized as *per se* legal.

Clearly, the existence or absence of a colorable business justification is a question more suitably answered in the context of Blue Cross' overall "plan of attack" than by reference to any single element of that conduct.[19] The purpose of the McCarran-Ferguson statute is to prevent "impairment" of state insurance regulation, *i.e.*, to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). *Securities and Exchange Cmsn. v. National Securities, Inc.*, 393 U.S. 453 (1969); *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408 (1946). However, a state's ability to sanction specific conduct under its regulatory scheme should not be deemed "impaired" simply because evidence of that conduct is to be examined by a court in judging the legality of related conduct outside the "business of insurance"—*i.e.*, with regard to "Prudent Buyer."[20]

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[19] There was clear evidence in this case that neither HealthMate nor Adverse Selection were devised for legitimate business purposes. HealthMate was known from the outset to be unprofitable to Blue Cross and, indeed, it performed as predicted. It was never considered a long-term business product but only a "fighting ship" to attack Ocean State. Adverse Selection, likewise, was shown to be the result of arbitrary actuarial assumptions and statistical manipulations. Its purpose was to impose financial penalties on employers who offered Ocean State as an alternative to Blue Cross, as the court of appeals itself recognized.

[20] Whether HealthMate and Adverse Selection ultimately had the general approval of the State is not dispositive of their relevance

B. The Decision Below Reflects the Lack of Standards for Applying the "Coercion" Exception to the McCarran-Ferguson Act

The McCarran-Ferguson Act expressly excludes from its Sherman Act exemption "any . . . act of boycott, coercion, or intimidation." 15 U.S.C. § 1013(b). In summarily concluding that Blue Cross' economic pressure directed against employers offering the Ocean State plan to their employees did not amount to "coercion" within the meaning of the Act, the court below distorted the definition of coercion developed elsewhere in antitrust law. The court, thereby, inappropriately expanded the McCarran-Ferguson exemption—an exemption that is to be construed narrowly. *Royal Drug*, 440 U.S. at 231.

The court below recognized the dearth of case law interpreting "coercion" in the McCarran-Ferguson context. 883 F.2d at 1109 n.9. It is clear, however, that the terms used in § 1013(b) are to be construed in light of the "tradition of meaning" given them under the Clayton and Sherman Acts. *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 541 (1978). The term "coercion" has been used by this Court in a variety of contexts to define conduct that is harmful to competition. The principal definitional issue is to distinguish actionable "coercion" from mere "persuasion" or "argument." *Ford Motor Co. v. United States*, 335 U.S. 303, 316-17 (1948).

Generally, the line between argument and coercion has been deemed to be crossed when economic power is used as a "club" to force a result that would not otherwise have been accomplished. *Id.* at 316-20 (approving jury instructions to that effect). "Coercive activity that prevents its victims from making free choices between mar-

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to the overall antitrust issue. State insurance regulators have no mandate to protect competition in provider service markets. Nor does state approval depend on the purpose of the conduct or its effect on overall price levels in the market for health insurance. Thus, consideration of the HealthMate and Adverse Selection as evidence of Blue Cross' composite design, and efficiency rationale is appropriate.

ket alternatives is inherently destructive of competitive conditions and may be condemned without proof of its actual market effect." *Associated Gen. Contractors of Cal. v. California State Council of Carpenters*, 459 U.S. 519, 528 (1983). This Court has recognized that arbitrary and unreasonable price differentials designed to penalize those who deal with an actor's competitors constitute "coercive" conduct actionable under the Sherman Act. *United States Navigation Co. v. Cunard S.S. Co.*, 284 U.S. 474, 479-80 (1932).

The court below plainly misconstrued the concept of coercion in light of the facts presented. Blue Cross' strategy of charging higher prices only to employers who offered Ocean State as an alternative to Blue Cross was designed to force those employers to forego their choice to offer a competing health plan as the court below conceded. 883 F.2d at 1104 n.4. The coercive intent of this strategy was demonstrated at trial by evidence that the "estimates" of Ocean State enrollment and other "actuarial" assumptions behind the Adverse Selection discriminatory pricing scheme were arbitrary. This was not, as the court below suggested, an attempt to "lure" employers away from Ocean State by persuading them of the competitive merits of Blue Cross. Rather, it was a bald effort to suppress competition on the merits through economic duress.

C. This Court Should Reconsider the Extent to Which Passive State Regulation Is Sufficient to Invoke the McCarran-Ferguson Exemption

The court below determined that both HealthMate and Adverse Selection fell within the "business of insurance" for purposes of McCarran-Ferguson exemption.[21] It did so in the face of evidence that the initiation of Adverse

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[21] The appellate court reached this determination notwithstanding Blue Cross' failure to raise the issue on appeal with respect to HealthMate. 883 F.2d at 1107 n.6.

Selection preceded the Rhode Island Department of Business Regulation ("DBR") approval and that DBR was never required to approve the specific elements of HealthMate and Adverse Selection. 883 F.2d at 1103 n.1, 1108-09. This holding raises two issues which merit consideration by this Court.

First, the holding below extends the shield of the McCarran-Ferguson Act to conduct (Adverse Selection) that was undertaken in advance of the required state regulatory approval. As the exception for acts of boycott and coercion indicates, the McCarran exemption cannot be used to shield one illegal act with another. This conclusion has been suggested in other contexts.[22]

A second, and broader, question raised by the decision below is whether the McCarran-Ferguson exemption should continue to be liberally construed as to exclusionary conduct that is not actively supervised by the state. Historically, this Court has indicated that the existence of a general regulatory scheme is sufficient to satisfy the "regulated by state law" requirement of the McCarran-Ferguson Act. *FTC v. National Casualty Co.*, 357 U.S. 560 (1958). The lower courts, over time, have construed this teaching most generously to the benefit of insurers.[23]

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[22] *See United States v. Sylvanus*, 192 F.2d 96 (7th Cir. 1951), *cert. denied*, 342 U.S. 943 (1952) (McCarran-Ferguson Act does not bar mail fraud prosecution against insurer; relying in part on finding that insurer's conduct was in derogation of state regulatory directives); *Washburn v. Brown*, 1986 WL 7062 (N.D. Ill. 1986) (insurer's scheme to defraud state insurance department and policy holders by misrepresenting compliance with regulatory requirements not exempted from RICO suit by McCarran-Ferguson Act.) Like the defendants in *Sylvanus* and *Washburn*, Blue Cross seeks the protection of a regulatory scheme which it flouted in order to undertake its exclusionary conduct.

[23] Thus, the exemption has been applied in cases where no statute or regulation specifically governs the challenged practice. *McIlhenny v. American Title Ins. Co.*, 418 F. Supp. 364 (E.D. Pa. 1976), as well as to cases in which state regulations are not enforced. *Lawyers Title Co. v. St. Paul Title Ins. Corp.*, 526 F.2d 795 (8th Cir. 1975). Indeed, entirely permissive regulatory schemes have been held to

In view of the narrow construction of the "business of insurance" emphasized in more recent decisions of this Court, a continued *laissez-faire* approach to the state regulation requirement is incongruous.

In this regard, it may be observed that the McCarran-Ferguson approach to state regulation is decidedly less restrictive than that required by the state action doctrine. But the two exemptions, even though distinct, are virtually identical in purpose. Indeed, courts have invoked both doctrines in a combined analysis. *See, e.g., Allstate Insurance Co. v. Lanier*, 361 F.2d 870, 872-73 (4th Cir. 1966).

The state supervision requirement has been the focus of recent state action cases in this Court. *Patrick v. Burget*, 486 U.S. 94, 108 S. Ct. 1658 (1988); *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980). Those decisions indicate a view that federal-sate conflict is more likely to be avoided, and that abuses are better controlled, when the state evinces an active commitment to its regulatory objectives. "Absent such a program of supervision, there is no realistic assurance that a private party's anticompetitive conduct promotes state policy, rather than merely the party's individual interests." *Patrick*, 108 S. Ct. at 1663.

Presently, however, such assurance is lacking with regard to the actions of private insurers. No specific articulation or supervision is necessary to sanction competitive abuses as long as the conduct can be squeezed within the general regulation of the business of insurance.[24] Thus, the sufficiency of state regulation has been

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preclude federal causes of action. *State of Ohio v. Ohio Med. Indem., Inc.*, 1976-2 Trade Cas (CCH) ¶ 61,128 at 70,110 (S.D. Ohio).

[24] That fact has troubled the courts. *See, e.g., Ohio Med. Indem.*, 1976-2 Trade Cas. at 70,113 ("Were the Court writing on a clean slate, it would be persuaded that the State of Ohio does not 'regulate' the business of . . . insurance as it relates to the allegations in the complaint.") *In re Aviation Ins. Indus.*, 183 F. Supp. 374 (S.D.N.Y. 1960) (holding exemption inapplicable where state regulation not specifically directed to subject matter in question).

raised before this Court as recently as *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), but ultimately was not the basis for decision in that case. 458 U.S. at 134 n.9.

The significance of the state regulation requirement lies in the fact that insurance regulation, in and of itself, promotes objectives that are not necessarily congruous with those of the antitrust laws, and, to the extent McCarran-Ferguson is applicable, an explicit tradeoff is made between state regulatory objectives and price competition. Moreover, to the extent insurance practices restrain trade in related non-insurance markets—*e.g.*, the market for physician services—where state regulators have no mandate to protect consumer welfare, the need for, and legitimacy of, regulatory immunity is further attenuated. Thus, the clarity of the state commitment to regulate the conduct in question is critical.

The decision below well illustrates the problems which the historical interpretation of "state regulation" has engendered. The ultimate "approval" of Adverse Selection by the state—sought only after the state directed Blue Cross to do so—consisted solely of the approval of a rating formula. Blue Cross remained free, unsupervised by the state, to manipulate its estimates of subscriber loss and health status, *i.e.*, the numbers to which the formula would be applied, in order to achieve a coercive price differential to be charged employers that offered the competing Ocean State plan. That unregulated element of Adverse Selection, however, was the relevant conduct in Blue Cross' overall predatory strategy, and nothing in state regulation supervised the outcome.

Likewise, the HealthMate product merely was approved for sale by the State of Rhode Island. The manner in which it was marketed—only to employers that offered Ocean State—and the price at which it was offered were not approved. The decision below plainly illustrates how

effectively insurers may use unsupervised conduct to harm competition.

III. THIS COURT SHOULD GIVE EFFECT TO THE INDEPENDENT OBJECTIVES OF STATE TORT LAW

By determining that the Sherman Act controls the disposition of Ocean State's tort claim, both the district court and the court of appeals inappropriately imposed a federal standard on state tort law. In light of the frequency with which pendent state law claims are raised in federal antitrust suits, this Court should review the holding below and address the obligation to give effect to the acts of the state legislatures. In Rhode Island, the tort of interference with contractual relationships is defined as an "unfair" act which diminishes the value of a contract. *Smith Development Corp. v. Bilow Enters., Inc.*, 112 R.I. 203, 308 A.2d 477 (1973). Although conduct which is independently wrongful—*e.g.*, because it violates the antitrust laws—may be deemed presumptively ill-motivated for purposes of tort law, *see* Restatement (Second) of Torts § 767, comment d, it does not follow that a finding that the Sherman Act has not been violated is dispositive of a tort claim arising from the same conduct. The concept of "unfair" competition is decidedly different in scope and objective from the antitrust laws. *See* McCarthy, Trademarks and Unfair Competition § 1:14. Accordingly, the use of the Sherman Act to interpret and decide the pendent tort claim denied Ocean State the protection of state law to which it was entitled. Federal courts should not act so precipitously in respect to state interests.

CONCLUSION

The decision below creates a special rule of *per se* legality which effectively immunizes exclusionary conduct by a health insurer from Sherman Act scrutiny. The same analytical failing led the court below to misconstrue critical aspects of the McCarran-Ferguson Act exemption, and to ignore independent principles of state tort law. For the reasons stated, the writ of certiorari should issue to review the judgment of the United States Court of Appeals for the First Circuit.

Respectfully submitted,

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APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

No. 88-1851

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Plaintiffs-Appellants,

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND,
Defendant, Appellee.

Appeal from the United States District Court
for the District of Rhode Island
[Hon. Francis J. Doyle, *U.S. District Judge*]

Before
Campbell, *Chief Judge*,
Bownes, *Circuit Judge*,
and Caffrey,* *Senior District Judge.*

Stuart M. Gerson with whom *William G. Kopit, Epstein, Becker & Green, P.C., Thomas E. Lynch* and *Lynch and Greenfield* were on brief for appellants.

Steven E. Snow with whom *James E. Purcell, Partridge, Snow & Hahn, Elia Germani, Joshua F. Greenberg, Michael Malina*, and *Kaye, Scholer, Fierman, Hays & Handler* were on brief for appellee.

August 21, 1989

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* Of the District of Massachusetts, sitting by designation.

CAMPBELL, *Chief Judge.* Plaintiffs, Ocean State Physicians Health Plan, Inc. ("Ocean State") and a certified class of Ocean State's participating physicians, brought suit against Blue Cross & Blue Shield of Rhode Island ("Blue Cross"), alleging that Blue Cross had acted unlawfully to exclude Ocean State from the health care insurance marketplace. A jury found that Blue Cross was guilty of violating section 2 of the Sherman Act, 15 U.S.C. 2 (1982) and also was liable under Rhode Island common law for tortiously interfering with the contractual relationships between Ocean State and the physicians. The district court subsequently ruled, however, that the challenged conduct was legitimate competitive activity of a sort that is favored—not prohibited—by the antitrust laws. Accordingly, the court granted judgment inotwithstanding the verdict to Blue Cross on both the antitrust and tortious interference claims. We affirm the district court's judgment.

I. FACTUAL BACKGROUND

Defendant Blue Cross, a non-profit corporation established in 1939, has long been the largest health insurer in Rhode Island. It purchases health services from physicians, hospitals, and other health care providers on behalf of its subscribers. Blue Cross underwrites the cost of these purchases by spreading the risk of health care expenses among its subscriber groups. Plaintiff Ocean State is a for-profit health maintenance organization ("HMO") that began operations in 1984. Like Blue Cross, Ocean State contracts with physicians to provide medical care to its subscribers, and then pays its contracted physicians on a fee-for-service basis. While Blue Cross will reimburse its subscribers even for certain services performed by non-participating physicians, Ocean State does not pay for services by non-participating physicians. Eighty percent of the shares of the Ocean State corporation are owned by its participating physicians. A physician may participate in more than one

health insurance program. Thus, a physician may contract with Blue Cross, with Ocean State, or with both.

From its inception, Ocean State grew rapidly. Like Blue Cross, it was offered to subscribers through employers. Apparently because Ocean State provided more coverage and charged lower premiums, many subscribers switched from Blue Cross to Ocean State. By the spring of 1986, Blue Cross had lost approximately 30,000 of its 543,015 enrollees, while Ocean State's enrollment had exceeded all expectations, growing to 70,000. *See Ocean State Physicians Health Plan, Inc.* v. *Blue Cross & Blue Shield of Rhode Island*, 692 F. Supp. 52, 57 (D.R.I. 1988). Because Blue Cross was experiencing financial problems, it had to raise its premiums in order to maintain adequate financial reserves. As it raised its premiums, it lost more enrollees—which, in turn, forced further rate increases. In short, Blue Cross "was faced with a serious competitive problem." *Ocean State*, 692 F. Supp. at 57.

In the spring of 1986, to meet the challenge presented by Ocean State, Blue Cross instituted a three-pronged attack:

First, Blue Cross launched its own HMO "look-alike," dubbed HealthMate, which it marketed to employers who were offering the Ocean State plan to their employees. Like Ocean State, HealthMate provided 15 percent more coverage than the standard Blue Cross plan, including such added benefits as office visits, prescription drugs, and "good health" benefits. Like Ocean State, but unlike traditional Blue Cross, HealthMate paid only for services provided by participating physicians. In those employer groups in which employees were required to contribute to their premiums, HealthMate was offered at 5 percent below the cost of traditional Blue Cross. 692 F. Supp. at 58.

Second, Blue Cross instituted an "adverse selection" policy of pricing. "Adverse selection" refers to the

tendency for younger and healthier people to opt for HMOs such as Ocean State when they are made available, leaving older and sicker people (on the average) in the standard Blue Cross pool. Because of such adverse selection, Blue Cross expected the health care costs for standard Blue Cross to be higher in those employer groups that offered an HMO option than in those employer groups that did not. With the approval of the Rhode Island Department of Business Regulation ("DBR"), Blue Cross instituted a pricing plan that took account of this projected difference in health expenses.[1] Under this policy, employers were offered three different rates for traditional Blue Cross coverage. The rate was lowest for an employer who offered *only* traditional Blue Cross, intermediate for an employer who also offered a competing HMO (usually Ocean State) and HealthMate, and highest for an employer who also offered a competing HMO but declined to offer HealthMate.

Third, Blue Cross initiated a policy, which it called "Prudent Buyer," of not paying a physician more for any service or procedure than that physician was accepting from any other health care cost provider (such as Ocean State). Blue Cross established this policy after it became apparent that Ocean State's contracting physicians were accepting about 20 percent less for their services from Ocean State than they were receiving from Blue Cross. Ocean State had withheld 20 percent of its physicians' fees in 1985, with the expectation that if the corporation made a profit the withhold would be returned. Ocean State did not turn a profit, however, and the withhold was not returned. In 1986 Ocean State again withheld 20 percent of its physicians fees, which it again failed

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[1] Blue Cross established the adverse selection policy in June 1986, without approval from DBR. In October 1986, DBR ordered Blue Cross to suspend the policy until it obtained DBR approval. On November 12, 1986, the DBR approved Blue Cross's rate formula, and Blue Cross resumed its use.

to return after the end of the year. In order to ensure that it was getting the physicians' best prices, Blue Cross required each of its participating physicians to certify that he or she was not accepting any lower fees from other providers than he or she was receiving from Blue Cross for the same service. If the provider failed to provide such certification, Blue Cross reduced that physician's fees by 20 percent. As a result of the Prudent Buyer policy, Blue Cross achieved significant cost savings. After the implementation of Prudent Buyer, about 350 of Ocean State's 1200 physicians resigned, in many cases apparently in order to avoid a reduction in their Blue Cross fees.

II. PROCEDURAL BACKGROUND

Ocean State, together with a certified class of its participating physicians, brought this suit against Blue Cross. Ocean State [2] alleged that Blue Cross's conduct violated, inter alia, section 2 of the Sherman Act, which makes it unlawful to "monopolize . . . any part of the trade or commerce among the several States." 15 U.S.C. § 2.[3] Ocean State charged that Blue Cross launched

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[2] Here and at other points, in this opinion we use the term "Ocean State" to refer collectively to both plaintiffs—Ocean State itself and the class of participating physicians.

[3] Under section 4 of the Clayton Act, 15 U.S.C. § 15 (1982), any person injured by such unlawful monopolization may bring suit for treble damages, and under section 16 of the Clayton Act, 15 U.S.C. § 26 (1982), any person threatened with such injury may sue for injunctive relief.

Ocean State also claimed that Blue Cross had violated section 1 of the Sherman Act, 15 U.S.C. § 1 (1982), which prohibits contracts, combinations, and conspiracies in restraint of trade. Ocean State alleged that Blue Cross had violated section 1 by (1) attaining monopoly power through a merger between Blue Cross and Blue Shield in 1982, and (2) conspiring with the Rhode Island Group Health Associaiton ("RIGHA"), the only HMO operating in Rhode Island before 1984, to control hospital discounts. At the close of the plaintiffs' case, the district court directed a verdict in

HealthMate not because it was a viable long-term product, but in order to put Ocean State out of business. Through the adverse selection policy, Ocean State claimed, Blue Cross was able to raise its rates for standard Blue Cross for employer groups offering HealthMate—which, in turn, influenced employers not to make HealthMate available.[4] Finally, Ocean State claimed that Blue Cross instituted the Prudent Buyer policy not in order to save money, but rather to induce physicians to resign from Ocean State. Plaintiffs also raised a pendent state law claim: that Blue Cross's conduct tortiously interfered with the contractual relationships between Ocean State and the members of the class of Ocean State physicians.

After a lengthy trial, the jury found Blue Cross "guilty" on the section 2 claim, but it awarded no damages on this claim. The jury also found that Blue Cross

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favor of Blue Cross on the section 1 claims. The court ruled that there was no evidence that the Blue Cross-Blue Shield merger had an anticompetitive effect, and that there was no evidence that plaintiffs were injured as a result of the agreement between Blue Cross and RIGHA. Ocean State does not seriously challenge this directed verdict on appeal. In a footnote to its brief, Ocean State suggests only that if this court were to order a new trial on antitrust matters, plaintiffs should be entitled to press their section 1 claims. At oral argument, Ocean State's counsel said that it had addressed the section 1 claims "en passant." This "en passant" presentation did not suffice to preserve the section 1 issue on appeal, and therefore we will not consider it further.

[4] It might seem incongruous at first blush for Ocean State to allege that Blue Cross engaged in anticompetitive behavior by *raising* its rates. Such allegations of anticompetitive conduct are usually reserved for cases in which companies *lower* their rates, incurring short-term losses for the purpose of undercutting competitors and putting them out of business. Here, however, Ocean State argues plausibly that many employers felt committed to offer Blue Cross to their employees. Since their Blue Cross rates would increase if they also offered Ocean State, these employers allegedly felt pressure not to adopt (or to drop) Ocean State in order to keep their Blue Cross rates down. The personnel manager of one company testified to this effect at trial.

had tortiously interfered with plaintiffs' contractual relationships. On the latter claim it awarded the Ocean State Physicians Health Plan $947,000 in compensatory damages and $250,000 in punitive damages; and it awarded the members of the physician Class $1,746,437 in compensatory damages. Following the verdict, Blue Cross moved for judgment notwithstanding the verdict on both claims and, in the alternative, for a new trial on the tortious interference claim. Ocean State, for its part, moved for an injunction against Blue Cross's continuation of the challenged policies, as well as for a $1.9 million additur to the jury award to the physician class.

In its opinion, 692 F. Supp. at 74, the district court granted Blue Cross's motion for judgment notwithstanding the verdict on both the antitrust and tortious interference claims. The court reached its result with respect to the antitrust claims on alternative grounds. First, the court reasoned that the jury's award of "no damages" on the antitrust claim meant that plaintiffs had failed to prove that they had been injured by any illegal conduct by Blue Cross. Second, the court held that, quite aside from the "no damages" verdict, Ocean State plaintiffs had failed to show that Blue Cross's actions were anything other than legitimate acts of competition. Having determined that Blue Cross had not violated the antitrust laws, the district court also granted Blue Cross judgment notwithstanding the verdict on the state law claim of interference with contractual relationship relationships. The court noted that Blue Cross's policies were "*justified* responses to competitive conditions," *id.* at 73 (emphasis added), and therefore could not as a matter of law constitute tortious interference with contractual relationships. In light of these conclusions, the district court also denied Ocean State's motions for injunctive relief and for an additur. Ocean State appeals from these rulings of the district court.

III. STANDARD OF REVIEW

In ruling on a defendant's motion for judgment notwithstanding the verdict, the district court must evaluate the evidence in the light most favorable to plaintiffs. *Rios* v. *Empresas Lineas Maritimas Argentinas*, 575 F.2d 986, 989 (1st Cir. 1978). "The motion is properly granted only when, as a matter of law, no conclusion but one can be drawn." *Id.* at 990. We adopt the same standard in reviewing the district court's judgment. At the same time, we note that "the trial court as well as this court has an obligation to render judgment as a matter of law when it is clear from the evidence that such is required." *United States* v. *Articles of Drug Consisting of the Following: 5,906 Boxes*, 745 F.2d 105, 113 (1st Cir. 1984).

IV. THE ANTITRUST CLAIM

In addressing Ocean State's antitrust claim, we first consider the effects on that claim of the jury's "guilty/no damages" verdict. We decline to utilize the jury's failure to award damages as a basis for upholding the lower court's entry of judgment notwithstanding the verdict for Blue Cross. We then consider the applicability of the McCarran-Ferguson Act, which under certain circumstances exempts the "business of insurance" from the antitrust laws. We conclude that by reason of McCarran-Ferguson both HealthMate and the adverse selection policy are exempt from antitrust scrutiny. Finally, we consider whether the Prudent Buyer policy can as a matter of law be found to be an instance of prohibited monopolization, rather than legitimate competitive activity, and we conclude that it cannot.

A. *The "Guilty/No Damages" Verdict*

As a general rule, a verdict of liability with no damages may require that judgment be entered for the defendant. This court has held, for example, that when a jury found in favor of the plaintiff but assessed "zero"

damages under a state automobile dealers act and related tort and contract claims, the "plaintiff ha[d] failed to establish an essential part of its proof [*i.e.*, a showing of damages], and judgment should have been entered for defendant." *Poulin* v. *Chryler Corp.*, 861 F.2d 5, 7 (1st Cir. 1988) (citing *Association of Western Railways* v. *Riss & Co.*, 299 F.2d 133, 135 (D.C. Cir.), *cert. denied*, 370 U.S. 916 (1962)). In *Western Railways*, similarly, the court held that defendants were entitled to judgments on claims raised under sections 1 and 2 of the Sherman Act because, although the jury had found "for" the plaintiff, it awarded no damages.

Despite this general rule, however, we hesitate to affirm the district court's judgment on the ground that the jury found Blue Cross "guilty" but did not award damages. The instant case presents two difficulties to that approach which—while we do not decide—cause us to turn elsewhere.

First, the present plaintiffs—unlike the plaintiff in *Poulin*—sought not only damages, but also injunctive relief. In a case of this sort, involving prayers for both damages and injunctive relief, a jury finding of liability is ordinarily a prerequisite to the court's equitable consideration of injunctive relief. *See Beacon Theatres, Inc.*, v. *Westover*, 359 U.S. 500 (1959) (order of trial must be arranged so that any issues common to a legal claim and an equitable claim are tried to a jury first, with the equitable claim resolved subsequently in light of the determination of the jury). But a finding of damages is not a necessary prerequisite to injunctive relief in a case like the present one. Section 4 of the Clayton Act, 15 U.S.C. § 15, under which Ocean State sought treble damages, requires proof of "*some* damage." *Zenith Radio Corp.* v. *Hazeltine Research, Inc.*, 395 U.S. 100, 114 n.9 (1969) (emphasis added). But section 16 of the Clayton Act, 15 U.S.C. § 26, under which plaintiffs sought injunctive relief, requires only "*threatened* loss or damages by

a violation of the antitrust laws" (emphasis added). *See Cargill, Inc.* v. *Monfort of Colorado, Inc.*, 479 U.S. 104, 111, 107 S. Ct. 484, 489 (1986) ("§ 4 requires a plaintiff to show actual injury, but § 16 requires a showing only of 'threatened' loss or damage"). Under this standard, a finding of actual damages may not necessarily be required. *Cf. Home Placement Service, Inc.* v. *Providence Journal Co.*, 573 F. Supp. 1423 (D.R.I. 1983), *rev'd in part on other grounds*, 739 F2d 671 (1st Cir. 1984), *cert. denied*, 469 U.S. 1191 (1985) (granting permanent injunction to prevent future antitrust violations, despite a damages award of only $3 in nominal damages). Therefore, the jury finding of liability but no damages on the antitrust claim arguably requires the lower court to consider awarding injunctive relief. If so, for us to determine whether or not the district court erred in denying Ocean State's motion for an injunction, we must deal first with the merits of the jury's finding of antitrust liability.

Second, although the jury awarded "no damages" on the antitrust claim, it awarded substantial damages to Ocean State and the physicians on the pendent state claim of interference with contractual relationships. Blue Cross and Ocean State agree that the antitrust and tortuous interference claims were based on the same pattern of conduct. Moreover, the jury had evident difficulty in deciding how to allocate the damage award between the two claims. Common sense suggests that under these circumstances, the damage award for tortious interference may have represented the jury's assessment of antitrust injury as well.[5] To the extent that this is likely, a

[5] The jury initially awarded *each* plaintiff, Ocean State and the physician class, compensatory damages of $2,693,437 and punitive damages of $250,000, undifferentiated as to claim. Noting that Ocean State and the physicians allegedly suffered distinct injuries, the court instructed the jury that it must award damages separately for each plaintiff and for each claim. After further deliberation, the jury awarded Ocean State compensatory damages of $947,000

new trial might be necessary in order to rule out the possibility that the jury's verdict was a product of confusion. By dealing with the finding of antitrust liability on its merits, we are able to avoid this problem. We turn, therefore, to the question whether, as a matter of law, an antitrust verdict in plaintiffs' favor could permissibly stand.

B. *The Effect of the McCarran-Ferguson Act*

The McCarran-Ferguson Act ("the Act"), 15 U.S.C. §§ 1012(b), 1013(b), exempts from the antitrust laws all conduct that is (1) part of the "business of insurance"; (2) "regulated by State law"; and (3) not in the form of "boycott, coercion, or intimidation.' Blue Cross argued to the district court that both the introduction of HealthMate and the use of the adverse selection rate factors—but not the Prudent Buyer policy—were exempted from antitrust scrutiny by the Act.[6] The district

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and punitive damages of $250,000 and awarded the physicians compensatory damages of $1,746,437. But the verdict forms did not indicate whether the awards were for damages on the antitrust claim, the tortious interference claim, or both. The district court then instructed the jury that it must specify the claims upon which it awarded damages. Finally, on its third try, the jury awarded "no damages" on the antitrust claim and the same damages as on the second verdict form on the tortious interference claim. In light of the jury's evident difficulty in apportioning the damages between the two claims, it is altogether possible that the jury viewed the damages as stemming from *both* the antitrust violations and the tortious interference. Inasmuch as the jury had been instructed that it could not award damages twice for the same injury, it could not assign the damages to both claims. The jury was not instructed—as perhaps it should have been—that it could assign the same amount to each claim, with the proviso that any award reflecting the overlapping of the two claims was to be made once, not twice.

[6] On this appeal Blue Cross presses its argument with respect to the use of the adverse selection factors, but not with respect to HealthMate. But Blue Cross raised the issue with respect to

court declined to rule on this argument. We find, however, that the McCarran-Ferguson exemption applies both to HealthMate and to the use of the adverse selection factors.

1. *The "business of insurance."* The central issue with respect to the applicability of the McCarran-Ferguson Act is whether HealthMate and adverse selection are part of the "business of insurance." 15 U.S.C. § 1012(b). The Supreme Court has identified "three criteria relevant in determining whether a particular practice is part of the 'business of insurance' exempted from the antitrust laws":

> *first*, whether a particular practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Union Labor Life Insurance Co. v. *Pireno*, 458 U.S. 119, 129 (1982). *See also Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205, 210-17 (1979). The Court went on to note that "none of these criteria is necessarily determinative in itself." *Pireno*, 458 U.S. at 129.

Both HealthMate and the adverse selection policy qualify as the "business of insurance" under these criteria. HealthMate is an insurance policy which operates by spreading policyholders' risk; adverse selection is a pricing policy that inherently involves risk-spreading. Both HealthMate and adverse selection directly involves the relationship between the insurer (Blue Cross) and the insured (its policyholders). Such policies are, more

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HealthMate in the court below, and Ocean State responded to the argument with respect to HealthMate in its appellate brief. Therefore, we do not think that the argument with respect to HealthMate has been waived.

or less by definition, limited to entities in the "insurance industry" as broadly construed. *Accord Health Care Equalization Committee* v. *Iowa Medical Society*, 851 F.2d 1020, 1029 (8th Cir. 1988).

Ocean State argues that "service benefit plans," such as Blue Cross, should not be deemed insurers for McCarran-Ferguson purposes. It bases this argument on a misreading of *Royal Drug*, 440 U.S. 205. In that case, the Supreme Court characterized Blue Shield's contacts with its *health care providers* as "merely arrangements for the purchase of goods and services by Blue Shield." *Id.* at 214. But the Court took care to distinguish Blue Shield's provider contracts from its subscriber contracts:

> This is not to say that the contracts offered by Blue Shield to its policyholders, as distinguished from its provider agreements . . . , may not be the 'business of insurance' within the meaning of the [McCarran-Ferguson] Act.

Id. at 230 n.37. This distinction was emphasized in Justice Brennan's dissenting opinion:

> Neither the Court . . . nor the parties challenge the fact that the . . . policy offered by Blue Shield to its policyholders—as distinguished from the contract between Blue Shield and the [providers]—is the "business of insurance." Whatever the merits of scholastic argument over the technical definition of "insurance," the policy both transfers and distributes risk. The policyholder pays a sum certain—the premium—against the risk of the uncertain contingency of illness, and if the company has calculated correctly, the premiums of those who do not fall ill pay the costs of benefits above the premiums of those who do.

Id. at 239 (Brennan, J., dissenting) (citation omitted).

Since *Royal Drug*, the focus of the McCarran-Ferguson inquiry has been the nature of the conduct alleged to vio-

late the antitrust laws, not whether the defendant is a traditional insurance company.[7] Accordingly, contracts between a Blue Cross plan and its subscribers have been found to be the "business of insurance" within the meaning of the Act. *See Health Care Equalization Committee*, 851 F.2d at 1020, 1028; *Anglin* v. *Blue Shield of Virginia*, 693 F.2d 315, 317-320 (4th Cir. 1982).

Ocean State also argues that Blue Cross's marketing and pricing practices with respect to HealthMate do not in themselves have the effect of transferring or spreading the policyholder's risk. But inasmuch as a health insurance policy is itself part of the "business of insurance," *see, e.g., Health Care Equalization Committee*, 851 F.2d 1020, 1028; *Anglin*, 693 F.2d 315, 317-320, we believe that the marketing and pricing of such policies are also part of the same business. The exemption offered to state-regulated insurance activities by the McCarran-Ferguson Act would be thin indeed if it were deemed to cover the content of policies, but not the marketing and pricing activities which necessarily accompany these policies. Indeed, in *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969), the Supreme Court noted that "the fixing of rates" and "[t]he selling and advertising of policies" are part of the "business of insurance" under the McCarran-Ferguson Act.

We conclude, therefore that both HealthMate and adverse selection are part of the "business of insurance" under the McCarran-Ferguson Act.

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[7] For this reason, Ocean State's observation that under Rhode Island law Blue Cross is considered not to be "part of the insurance industry," *Hospital Service Corp.* v. *West*, 112 R.I. 164, 178, 308 A.2d 489, 497 (1973), is not dispositive. Whether or not Blue Cross is considered to be "in the insurance business" for certain purposes, the challenged *activities* still constitute "the business of insurance." "The exemption is for the 'business of insurance,' not the 'business of insurers.'" *Royal Drug*, 440 U.S. at 211.

2. *Regulation by state law.* Turning to the second requirement for exemption under the Act, it is clear that both HealthMate and the adverse selection policy were "regulated by state law." The Rhode Island Department of Business Regulation approved the marketing of HealthMate, as well as the adverse selection rating formula. Ocean State protests that DBR did not approve the specific elements of HealthMate and adverse selection that Ocean State is challenging—for example, the decisions as to where and at what price to offer HealthMate, and the specific projections (which were plugged into the adverse selection formula) of the number of employees who would switch from standard Blue Cross to HMOs. In demanding this level of specificity, however, Ocean State misinterprets the provision of the Act that limits the exemption to conduct that is "regulated by State law." 15 U.S.C. § 1012(b). The Supreme Court has suggested that this requirement is satisfied by general standards set by the state. *See Federal Trade Commission* v. *National Casualty Co.*, 357 U.S. 560, 564-65 (1958). As the Fourth Circuit has put it more recently, "A body of state law which proscribes unfair insurance practices and provides for administrative supervision and enforcement satisfies the state regulation requirement of the exemption." *Mackey* v. *Nationwide Insurance Cos.*, 724 F.2d 419, 421 (4th Cir. 1984) (citing *FTC* v. *National Casualty Co.*).[8]

3. *"Boycott, coercion, or intimidation."* The McCarran-Ferguson Act specifically excepts from the ex-

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[8] Ocean State also argues that the adverse selection policy is not exempted by the McCarran-Ferguson Act because Blue Cross began using the adverse selection formula before state approval was obtained. *See* note 2, *supra*. But this lapse on Blue Cross's part has little bearing on whether the use of the adverse selection factors was "regulated by state law." It was precisely because of the presence of a comprehensive state regulatory system that DBR was able to order Blue Cross to suspend its use of the adverse selection formula, and Blue Cross did not resume its use until after DBR approval was obtained.

emption any "act of boycott, coercion, or intimidation." 15 U.S.C. § 1013(b). Ocean State argues in its reply brief that "the very purpose of the adverse selection factors was to coerce employers not to offer Ocean State or, failing that, at least to coerce employers into also offering HealthMate whenever Ocean State was offered." We do not believe, however, that this amounts to an allegation of "coercion" under the meanig of the Act.[9] Although Blue Cross may have to lure employers and individual subscribers from Ocean State to HealthMate, Ocean State does not point to any evidence that any employer was *coerced* to offer HealthMate or not to offer Ocean State. Even the one personnel manager who testified that the adverse selection policy served to dissuade his company from offering Ocean State did not suggest that the policy left him no choice in the matter. He merely faced rate increases that were somewhat greater than they otherwise would have been.[10]

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[9] Much of the case law interpreting the provision focuses upon the "boycott" rather than the "coercion, or intimidation" aspect of the exception. *See, e.g., St. Paul Fire and Marine Insurance Co.* v. *Barry*, 438 U.S. 531 (1978). Coercion has not generally been interpreted to include situations where options have not been entirely closed off to the allegedly coerced parties, even though such options may have been made more expensive. In *Klamath-Lake Pharmaceutical Ass'n* v. *Klamath Medical Service Bureau*, 701 F.2d 1276 (9th Cir. 1983), *cert. denied*, 464 U.S. 822 (1984), for example, the requirement by a nonprofit provider of health insurance and health care services that its insureds use the provider's pharmacy to receive the pharmacy benefits under its policies did not amount to an attempt to boycott, coerce, or intimidate other pharmacies where the provider did not preclude its insurers from patronizing other pharmacies. *See also Feinstein* v. *Nettleship Co. of Los Angeles*, 714 F.2d 928 (9th Cir. 1983), *cert. denied*, 466 U.S. 972 (1984) (agreement between county medical association and medical malpractice insurers to offer malpractice insurance only to association members was not an agreement to boycott or coerce physicians to purchase carriers' insurance).

[10] In any event, Ocean State has waived the coercion argument. At trial, although the district court declined to rule on whether

We conclude that the challenged actions of Blue Cross with respect to HealthMate and adverse selection are exempt from antitrust scrutiny under the McCarran-Ferguson Act.

C. *The Prudent Buyer Policy.*

The Prudent Buyer policy involves Blue Cross's relationships not with its subscribers but with its provider physicians. Blue Cross makes no claim that this policy is protected by the McCarran-Ferguson exemption. *Cf. Royal Drug.* 440 U.S. 205 (contracts between Blue Shield and participating pharmacies not exempted from antitrust scrutiny). We agree with the district court, however, that the Prudent Buyer policy—through which Blue Cross ensured that it would not pay a provider physician any more for any particular service than she was accepting from Ocean State or any other private health care purchaser—is, as a matter of law, not violative of section 2 of the Sherman Act.

Section 2 of the Sherman Act makes it unlawful to "monopolize . . . any part of the trade or commerce among the several states." 15 U.S.C. § 2. The offense of monopolization has two elements:

> (1) the possession of monopoly power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident.

Blue Cross's conduct was covered by the McCarran-Ferguson exemption, it did rule that the exception did not apply, noting that "[t]here's no evidence of boycott, intimidation or otherwise." Ocean State apparently objected to this ruling but failed to take exception to it in its initial brief on appeal. It made no argument that Blue Cross's conduct took the form of coercion within the meaning of the McCarran-Ferguson Act. Ocean State's resurrection of this argument in its reply brief comes too late.

United States v. *Grinnell Corp.*, 384 U.S. 563, 570-71 (1966). On this appeal, Blue Cross does not dispute its monopoly power in the market for health care insurance in Rhode Island. Ocean State, for its part, concedes that Blue Cross acquired its historical advantages legitimately. The issue in dispute is whether Blue Cross *maintained* its monopoly position through improper means.

Section 2 does not prohibit vigorous competition on the part of a monopoly. To the contrary, the primary purpose of the antitrust laws is to encourage competition. *See, e.g., Standard Oil Co.* v. *Federal Trade Commission*, 340 U.S. 231, 248-49 (1951). What section 2 *does* prohibit is "exclusionary" conduct by a monopoly, often defined as "behavior that not only (1) tends to impair the opportunities of rivals, but also (2) either does not further competition on the merits or does so in an unnecessarily restrictive way." 3 P. Areeda & D. Turner, *Antitrust Law* ¶ 626b at 78 (1978), *quoted by Aspen Skiing Co.* v. *Aspen Highlands Skiing Corp.*, 472 U.S. 585, 605 n.32 (1985). To decide whether the Prudent Buyer policy can reasonably be found to be exclusionary, we must ask whether Blue Cross's conduct "went beyond the needs of ordinary business dealings, beyond the ambit of ordinary business skill, and 'unnecessarily excluded competition' " from the health care insurance market. *Barry Wright Corp.* v. *ITT Grinnell Corp.*, 724 F.2d 227, 230 (1st Cir. 1983) (citing *Greyhound Computer Corp.* v. *International Business Machines Corp.*, 559 F.2d 488, 498 (9th Cir. 1977), *cert. denied*, 434 U.S. 1040 (1978).

In the case at hand, the record amply supports Blue Cross's view that Prudent Buyer was a bona fide policy to ensure that Blue Cross would not pay more than any competitor paid for the same services. According to the policy, when physicians provided data on the lowest prices they accepted for particular services, and these prices were lower than those allowed by Blue Cross, Blue Cross lowered its price to match the lowest price ac-

cepted. When Ocean State physicians did not provide this price information, Blue Cross reduced its fee to the physicians by 20%, to correspond to Ocean State's 20% withhold. Blue Cross estimated that it saved $1,900,000 through this policy.

We agree with the district court that such a policy of insisting on a supplier's lowest price—assuming that the price is not "predatory" or below the supplier's incremental cost—tends to further competition on the merits and, as a matter of law, is not exclusionary. It is hard to disagree with the district court's view:

> As a naked proposition, it would seem silly to argue that a policy to pay the same amount for the same service is anticompetitive, even on the part of one who has market power. This, it would seem, is what competition should be all about.

Ocean State, 692 F. Supp. at 71.

This conclusion is also compelled by this court's holding in *Kartell* v. *Blue Shield of Massachusetts*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985) that a health insurer's unilateral decisions about the prices it will pay providers do not violate the Sherman Act—unless the prices are "predatory" or below incremental cost—even if the insurer is assumed to have monopoly power in the relevant market. *See id.* at 927.

Kartell concerned Blue Shield of Massachusetts's ban on balance billing, a price policy according to which Blue Shield paid participating physicians only if they agreed not to make any additional charges to the subscriber. We held that, for antitrust purposes, a health insurer like Blue Shield must be viewed "as itself the purchaser of the doctors' purchases." *Id.* at 924. As such, the insurer—like any buyer of goods or services—is lawfully entitled to bargain with its provider for the best price it can get. *See id.* at 928. "[E]ven if the buyer has monopoly power, an antitrust court . . . will not interfere with a buyer's (nonpredatory) determina-

tion of price." *Id.* at 929. In the present case, Ocean State does not contend that the prices paid under the Prudent Buyer policy were "predatory" or below anyone's incremental costs. As Blue Cross argues, the legality of the Prudent Buyer policy rests *a fortiori* upon the holding in *Kartell*. In that case, Blue Shield sought to limit the fees to be charged by the physician to the subscriber; here, Blue Cross is limiting the price that *it* pays to the physician for services it is purchasing.

Ocean State argues that *Kartell* is a "vertical" case (involving the effects of Blue Shield's policy on its provider physicians), while the present case is "horizontal" (involving the effects of Blue Cross's policy on its competitor, Ocean State). But the distinction is of no consequence. In both cases the challenged activity is the price that the buyer offers to the seller. Moreover, in *Kartell* the physician plaintiffs contended that Blue Shield's balance billing ban was anticompetitive horizontally as well as vertically. The physicians argued that Blue Shield's pricing policy enabled it to attract more subscribers, thus "increasing its dominance in the health insurance business." *Id.* at 929. We rejected this argument, noting that it "comes down to saying that Blue Shield can attract more subscribers because it can charge them less." *Id.* at 930. Such an outcome—more business at lower prices—would not ordinarily run afoul of the antitrust laws.[11] Citing a case that centered on an allegation of injury by a horizontal competitor, we concluded that "Blue Shield seems simply to be acting 'as every rational enterprise does, *i.e.*, [to] get the best deal possible.'" *Id.* at 929-30 (quoting *Travelers Insurance Co.* v. *Blue Cross of Western Pennsylvania*, 481 F.2d 80, 84 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973).

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[11] In the present case, Ocean State alleges that Blue Cross never actually passed along its savings to subscribers. But nothing turns on whether Blue Cross in fact lowered its rates. The fact remains that achieving lower costs is a legitimate business justification under the antitrust laws.

In *Kartell* we cited several additional reasons why an antitrust court should hesitate to invalidate the Blue Shield-physician price bargain. Noting that the prices at issue were *low* prices, not high prices, we observed that "courts . . . should be . . . reluctant to condemn too speedily . . . an arrangement that, on its face, appears to bring low price benefits to the consumer." *Id.* at 930-31 (citing *Barry Wright*, 724 F.2d at 231-34). We also expressed the view that courts should be reluctant to interfere in the domain of medical costs, "an area of great complexity where more than solely economic values are at stake." *Id.* at 931. Both of these considerations are relevant to the present case as well.

In one sentence of its opinion awarding judgment notwithstanding the verdict to Blue Cross, the district court stated that the same standards of anticompetitive conduct should apply to all market participants, regardless of their degree of market power: "There is no principle of antitrust law which would deny a business practice to any entity with market power and permit that practice on the part of a competitor who does not have market power." *Ocean State*, 692 F. Supp. at 71. Ocean State correctly observes that this sentence misstates the law. In fact, the definition of "exclusionary" conduct cited above, *supra* at 22, leaves open the possibility that certain "conduct is illegal when taken by a monopolist because it tends to destroy competition, although in the hands of a smaller market participant it might be considered harmless, or even 'honestly industrial.'" *Berkey Photo, Inc.* v. *Eastman Kodak Co.*, 603 F.2d 263, 274-75 (2d Cir. 1979) (citation omitted), *cert. denied*, 444 U.S. 1093 (1980). But the district court's ultimate judgment remains correct in this case, notwithstanding this misstatement. Even a monopoly can engage in a competitive course of conduct, so long as it does so for valid business reasons (such as the desire to get the lowest possible price), rather than in order to smother competition. *Compare*

Aspen Skiing, 472 U.S. at 608 (the jury's conclusion that a monopolist's conduct was exclusionary "is strongly supported by Ski Co.'s failure to offer any efficiency justification whatever for its . . . conduct") *with* the present case (in which the efficiency justification—lower costs—is evident).

Even if we assume that the Prudent Buyer policy, as written is legitimate, Ocean State argues that Blue Cross applied the policy in a way that was in fact directed at the illegitimate goal of destroying Ocean State, rather than at the legitimate goal of lowering costs. But we do not believe that the evidence, even when viewed in the light most favorable to Ocean State, supports this contention.

First, Ocean State contends that although the Prudent Buyer policy was neutral on its face, Blue Cross in fact applied it only to Ocean State physicians. But even if we assume for argument's sake that Blue Cross selectively applied Prudent Buyer in this way, its conduct remains legitimate. It was primarily Ocean State physicians who were selling their services at a lower price to another provider (Ocean State) than to Blue Cross. Indeed, it was Ocean State's lower pricing policy—in particular, its 1986 decision not to return its participating physicians' withholds for 1985—that gave rise to Prudent Buyer. Therefore, it seems only logical—and not illegitimate—for Blue Cross to have focused its efforts in applying Prudent Buyer on Ocean State physicians.

Second, Ocean State argues that Blue Cross initially applied its policy to Ocean State physicians even before it knew whether Ocean State would return the 20 percent withhold for 1986 to its physicians. This left open the possibility that Blue Cross, by reducing its payments to Ocean State physicians by 20 percent, would actually be paying *less* than Ocean State. But even if we assume

that these contentions are borne out by the record, we see nothing wrong with this conduct. Blue Cross offered to Ocean State physicians payment schedules that matched what they were *currently* accepting from Ocean State. The antitrust laws do not prevent a purchaser from making such an obviously reasonable and obtainable price bargain with a provider.

Third, Ocean State suggests that Blue Cross applied Prudent Buyer in a way that bribed some physicians into promising to resign from Ocean State. Ocean State contends that Blue Cross "exempt[ed] from Prudent Buyer some physicians who missed the Ocean State contractual cutoff date, and hence were automatically renewed for a year, if they pledged to drop out of Ocean State in the next year." The record does not support this allegation, however. The only evidence pointed to by Ocean State in support of this charge is the testimony of Thomas Aman, head of Blue Cross's professional relations department, that he had made such a promise to one podiatrist. Aman testified that he had thought the policy allowed for such an exemption, but then discovered that he had been mistaken. The evidence of a single instance of the misapplication of the Prudent Buyer policy is not enough to support the claim that the policy was used in an exclusionary way. Strikingly, not a single Ocean State physician testified that Blue Cross directly encouraged him or her to resign from Ocean State.[12]

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[12] Ocean State likens Blue Cross's conduct to the efforts of the A & P company, found to be illegal in *United States* v. *New York Great Atlantic & Pacific Tea Co.*, 173 F.2d 79 (7th Cir. 1949), "to exert pressure on suppliers either not to deal or to alter their dealings with A & P's competitors" (as summarized in *Travelers Insurance*, 481 F.2d at 85). We find the resemblance to be slight. A & P's pressure on suppliers included a refusal to buy from suppliers who sold to anyone else through brokers. This, in turn, closed out competitors—presumably including smaller groceries—who were

Finally, Ocean State points to evidence in the record that Blue Cross officials *hoped* that Prudent Buyer—together with HealthMate and adverse selection—would have the effect of destroying or weakening Ocean State. For example, there was testimony that Blue Cross's president had expressed—in none-too-polite terms—a desire to emasculate Ocean State. Another Blue Cross executive wrote in a handwritten note that "not one guy *in the state isn't going* to know the implication of signing with Ocean State" (emphasis in original). The jury may reasonably have concluded, on the basis of this and other evidence, that Blue Cross's leadership desired to put Ocean State out of business. But the desire to crush a competitor, standing alone, is insufficient to make out a violation of the antitrust laws. As this court has noted, " 'intent to harm' without more offers too vague a standard in a world where executives may think no further than 'Let's get more business,' and long-term effects on consumers depend in large measure on competitors' responses." *Barry Wright*, 724 F.2d at 232. As long as Blue Cross's course of conduct was itself legitimate, the fact that some of its executives hoped to see Ocean State disappear is irrelevant. Under these circumstances Blue Cross is no more guilty of an antitrust violation than a boxer who delivers a perfectly legal punch—*hoping* that it will kill his opponent—is guilty of attempted murder.

We conclude that the Prudent Buyer policy did not as a matter of law violate section 2 of the Sherman Act. The district court's judgment notwithstanding the verdict is therefore affirmed. Because we hold that Prudent Buyer does not violate the antitrust laws, we also affirm the district court's refusal to enjoin the continued use of this policy.

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unable to buy directly from suppliers. *See A & P*, 173 F.2d at 83. In contrast, there is no evidence that Blue Cross refused to deal with Ocean State physicians, or that it pressured Ocean State physicians to alter their dealings with Ocean State.

V. THE CLAIM OF TORTIOUS INTERFERENCE WITH CONTRACTUAL RELATIONSHIPS

We also conclude that the district court was correct in granting judgment notwithstanding the verdict on Ocean State's pendent state tort claim of intentional interference with contractual relationships. Ocean State alleged that Blue Cross's conduct "interfere[d] with existing contractual relationships between Ocean State and Class Members." This claim seems to relate only to the Prudent Buyer policy, which is the only one of the challenged Blue Cross practices that directly concerns Ocean State's relationships with the class members, its participating physicians. The district court charged the jury, without objection, on this limited theory.

To establish a claim for tortious interference with a contractual relationship under Rhode Island common law, the plaintiff must show "(1) the existence of a contract; (2) the alleged wrongdoer's knowledge of the contract; (3) his intentional interference; and (4) damages resulting therefrom." *Smith Development Corp.* v. *Bilow Enterprises*, 112 R.I. 203, 211, 308 A.2d 477, 482 (1973). Blue Cross may defend against a claim of tortious interference on the ground that any interference was *justified*. *See id.*; *Mesolella* v. *City of Providence*, 508 A.2d 661, 670 (R.I. 1986). Conduct in furtherance of business competition is generally held to justify interference with others' contracts, so long as the conduct involves neither "wrongful means" nor "unlawful restraint of trade." *Restatement (Second) of Torts* § 768 at 39 (1979). We are left to decide whether Prudent Buyer could have been found to be "wrongful" under Rhode Island law.

The district court correctly—and without objection—instructed the jury on the law with respect to justification:

> A Defendant's conduct does not constitute intentional interference with a contract if it is justified.

> As you have been instructed the law favors vigorous competition. Conduct is justified if it is action taken in legitimate competitive business activity. Competition means that a competitor will of necessity interfere with its competition. Thus the fact of interference is justified. It is only if the competitor uses methods of competition which are beyond those which competitors must expect to occur in the marketplace, that is, by competition which is based upon illegal [or] illegitimate means that you may find that any competitive action is unjustified.

Despite the jury's finding of liability, we hold that the Prudent Buyer policy was justified as a matter of law. As we have shown, Blue Cross's conduct was legitimate competitive activity that was not "illegal" under the antitrust laws. By the same token, and for essentially the same reasons, the conduct was not "wrongful" or "tortious" under state law. To be sure, not all business torts are "exclusionary" under the antitrust laws. *See* 3 P. Areeda & D. Turner, *Antitrust Law* ¶¶ 626d, 737b, 7381 (1978). In an appropriate case, a plaintiff might fail to establish an antitrust violation but still establish that certain torts had been committed. *See, e.g., Kartell*, 749 F.2d at 933-34 (noting the possibility that Blue Shield's conduct in that case, though not in violation of the Sherman Act, "might amount to minor business torts"). In the present case, however, Ocean State fails to allege any tortious activity other than precisely the same "anticompetitive" behavior alleged in its antitrust claim. Ocean State puts the matter this way in its brief:

> The evidence concerning interference with contract largely overlaps that addressed to the antitrust count (see pp. 5-26, *supra*). Without unduly repeating ourselves, we note that there was varied and significant evidence from which the jury was able to find that Blue Cross acted anticompetitively

> to harm Ocean State and the physician class rather than merely to adapt reasonably to competitive pressures.

Under these circumstances, the antitrust law provides the best available barometer—indeed the only available barometer—of whether or not Blue Cross's conduct can be found to be "wrongful" or "illegitimate"—and, hence, tortious. No other relevant tort standards have been called to our attention in the case law or otherwise. For the same reasons that we held that Prudent Buyer did not violate the Sherman Act, therefore, we hold that it could not as a matter of law constitute tortious interference with plaintiffs' contractual relationships. Accordingly, we affirm the district court's judgment notwithstanding the verdict on the tortious interference claim and we deny Ocean State's motion for an additur to the jury award to the physician class.

VI. CONCLUSION

For the reasons stated above, we affirm the district court's award of judgment notwithstanding the verdict to Blue Cross on both the Sherman Act and the tortious interference claims. We also deny Ocean State's motions for an injunction and for an additur in favor of the physician class.

Affirmed.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

No. 88-1851

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Plaintiffs-Appellants,

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND,
Defendant, Appellee.

JUDGMENT

Entered: August 21, 1989

This cause came on to be heard on appeal from the United States District Court for the District of Rhode Island, and was argued by counsel.

Upon consideration whereof, It is now here ordered, adjudged and decreed as follows: The judgment of the District Court is affirmed.

By the Court:

/s/ [Illegible]
Clerk

cc:
Messrs. Gerson and Snow

APPENDIX C

UNITED STATES DISTRICT COURT
D. RHODE ISLAND

Civ. A. No. 86-0598-B

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Plaintiffs,

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND,
Defendant.

July 27, 1988

Thomas A. Lynch, Lynch and Greenfield, Providence, R.I., William B. Kopit, Mark E. Lutes, Stuart Gerson, Epstein, Becker, Borsody & Green, P.C., Washington, D.C., for plaintiffs.

Patrick Quinlan, Quinn, Shectman & Teverow, Julius C. Michaelson, Providence, R.I., for plaintiff-intervenors.

Steven E. Snow, James Purcell, Partridge, Snow & Hahn, Providence, R.I., for defendant.

OPINION

FRANCIS J. BOYLE, Chief Judge.

STATEMENT OF FACTS

Defendant, Blue Cross & Blue Shield of Rhode Island, had been charged by Plaintiffs with restraint of trade and monopolization in violation of both federal and state law. After trial, a jury awarded Plaintiffs compensatory damages in the total amount of $2,693,437 and punitive

damages in the amount of $250,000 for wrongful interference with contractual relationships, and found that Blue Cross & Blue Shield of Rhode Island was guilty of monopolization but awarded it no damages. Now pending are the Defendant's motion for judgment notwithstanding the verdict on the antitrust and tortious interference with contractual relationships claims. In the alternative, the Defendant seeks a new trial only on the interference with contractual relationships claims and not on the antitrust claims. Plaintiffs seek injunctive relief and an additur on the antitrust claims. In addition, the Defendant filed a counterclaim against the Plaintiff-Intervenors, the Physicians and Surgeons Association of Rhode Island, Inc. and thirteen individual members of the class, to prevent the Plaintiff-Intervenors from collectively negotiating fees with Blue Cross.[1]

Plaintiffs claimed that the Defendant violated Sections One and Two of the Sherman Antitrust Act, 15 U.S.C. §§ 1, 2 (Supp. 1986), violated the analogous Rhode Island Antitrust Statutes, R.I.Gen.Laws § 6-36-1 to 26 (Supp.1985), and breached the common law duty not to wrongfully interfere with contractual relationships. The Plaintiff Ocean State Physicians Health Plan, Inc. and the Plaintiff class of physicians sought monetary damages against the Defendant due to Blue Cross's business programs which for short hand purpose of reference are called prudent buyer, adverse selection, and HealthMate. Plaintiffs claimed that those programs were unlawful. Plaintiffs sought a permanent injunction prohibiting De-

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[1] The Physicians and Surgeons Association of Rhode Island and nineteen individual physicians intervened seeking injunctive relief and monetary damages against Defendant Blue Cross, a claim dismissed at trial. The Defendant Blue Cross also claimed against the Plaintiff-Intervenors alleging that Plaintiff-Intervenors violated Section One of the Sherman Act by conspiring to collectively negotiate with Blue Cross and sought injunctive and declaratory relief. There is no present threat to negotiate; therefore, the claim is denied as premature.

fendant from using its prudent buyer and HealthMate programs.

THE PARTIES

The Plaintiffs, Ocean State Physicians Health Plan, Inc. (Ocean State) and Anthony J. Kazlauskas and Jeffrey C. Winters, on behalf of the class of physicians, commenced suit against the Defendant Blue Cross & Blue Shield in September 1986. The class of physicians was defined by a court order dated April 2, 1987 to include "all physicians who contract with Ocean State to provide physicians services and who are also reimbursed by Blue Cross & Blue Shield of Rhode Island for the provision of physician services to defendant's subscribers." The Defendant, Blue Cross & Blue Shield of Rhode Island, is a nonprofit hospital and medical services corporation which provides insurance for hospital and medical expenses.

Ocean State is a health maintenance organization (HMO) with headquarters in Warwick, Rhode Island. As an independent practice association type HMO, Ocean State contracts with physicians to provide medical care to its subscribers; Ocean State then pays its contracted physicians on a fee for service basis. Initially, subscribers paid little or no additional cost other than the premium paid to the HMO. The physicians' practice remained independent from the HMO.

In 1980, Ocean State submitted its license application to the Rhode Island Department of Health. It began operation by offering hospital and physicians costs coverage to employee groups of twenty-five or more. Originally, Medserco, a St. Louis based company managed Ocean State. Presently, United HealthCare, a Minnesota based company, manages Ocean State and is its single principal shareholder owning 20% of the stock. The remaining 80% of shares are held by some of the physicians who provide services to Ocean State subscribers. New Ocean State participating physicians pay up to

$1,000 to contract with Ocean State to provide health services to Ocean State subscribers.

Ocean State is a federally qualified HMO. It determines its rates based on a community rating method. 42 U.S.C. Section 300e-1(8) provides that an HMO may choose to group by individual or family but within the chosen group, rates are to be equal subject to adjustment factors, such as age and sex. State law permits Blue Cross & Blue Shield to base its premiums for employer groups on the prior actual experience of each particular insured group.

FACTUAL BACKGROUND—PROCEDURAL

In April 1987, the Court granted Plaintiff Winters' and Kazlauskas' motion for class certification after the Defendant failed to object. The class, as noted, included all physicians who contract with Ocean State and who are also reimbursed by Blue Cross & Blue Shield. It was estimated that 900 physicians were certified as members of the class.

Although in their original complaint Plaintiffs did not request a jury trial, they subsequently demanded a jury trial. At the conclusion of Plaintiffs' case, the Court granted the Defendant's motion for a directed verdict on all claims under Section One of the Sherman Act against Ocean State and the class of physicians. The Court also granted Blue Cross & Blue Shield's motion for a directed verdict against the Plaintiff-Intervenors. At the conclusion of the case, the jury returned a verdict finding Blue Cross & Blue Shield liable to both Ocean State and the class of physicians on the Section Two antitrust claims. The jury, however, awarded no damages. On the claim of tortious interference with contractual relationships, the jury found Blue Cross & Blue Shield liable to Ocean State and awarded compensatory damages of $947,000 and punitive damages of $250,000. The jury also found

Blue Cross & Blue Shield liable to the class of physicians on the interference with contractual relationships claim and awarded $1,746,437 in compensatory damages.

Pending before the Court are both equitable and legal claims. Plaintiffs move for a permanent injunction against prudent buyer and HealthMate. In addition, they seek an additur to the class of physicians on the antitrust claim. Defendant moves for a judgment notwithstanding the verdict on the antitrust claims and intentional interference with contractual relationships claims. In the alternative, the Defendant seeks a new trial on the claims of interference with contractual relationships.

FACTUAL BACKGROUND

For many years Blue Cross of Rhode Island and Blue Shield of Rhode Island were the unchallenged leading health care financing organizations in Rhode Island. Blue Cross of Rhode Island was incorporated in the 1930's as a non-profit hospital service corporation that provided insurance coverage for hospital services. Blue Shield of Rhode Island was incorporated later and limited its insurance coverage to payment of physician charges. Blue Cross of Rhode Island and Blue Shield maintained separate Boards of Directors, reserves, and auditing of financial statements.

Under an administrative services agreement, however, Blue Cross provided management and staff for Blue Shield. Usually Blue Cross and Blue Shield policies were marketed together as a package to employers. Occasionally, an employer could purchase Blue Cross coverage alone, but employees were not permitted to purchase only Blue Shield coverage. Neither Blue Cross nor Blue Shield were marketed with other health insurance.

In 1971, Rhode Island Group Health Association (RIGHA) a group model Health Maintenance Organiza-

tion (HMO) entered the Rhode Island health care financing market. A group model HMO employs physicians to serve the medical needs of its subscribers. Services are usually provided at a fixed location and this was initially true of RIGHA. RIGHA had little impact on Blue Cross & Blue Shield's share of the market. RIGHA entered into an agreement with Blue Cross & Blue Shield whereby RIGHA would purchase hospital services through Blue Cross. Thus, RIGHA enjoyed Blue Cross & Blue Shield hospital discounts; while Blue Cross & Blue Shield benefited because they then claimed RIGHA subscribers within their membership and thereby increased their claimed size of the market. As a result, Blue Cross was further able to negotiate favorable agreements for the cost of hospital care.

In addition, RIGHA entered into a joint marketing agreement with Blue Cross & Blue Shield to coordinate marketing activities. Both agreements were terminated in March 1982, after a newspaper article disclosed the arrangement. There was testimony, however, that the sharing of hospital and physician discounts continued through May 1986.

In 1980 at the time Ocean State applied to the Rhode Island Department of Health for licensing as an HMO, Blue Cross & Blue Shield continued to dominate the health care financing market. Blue Cross & Blue Shield controlled a very large percentage of the market. Competition from other health care financing insurers was virtually non-existent. RIGHA was then the only licensed HMO in Rhode Island and its market share was minimal.

Although Blue Cross & Blue Shield researched the financial background of Medserco, Ocean State's original management company, and considered using that information to discredit Ocean State's regulatory application, it did not do so. Blue Cross and Blue Shield took an active interest in Ocean State's licensing procedure, but

did not oppose the application. Subsequently Ocean States application was approved.

At about the same time Blue Cross and Blue Shield were negotiating a merger. In 1982, after two years of negotiations the two companies merged to form one corporation, Blue Cross & Blue Shield of Rhode Island, [hereinafter Blue Cross & Blue Shield] which provided both hospital and physician insurance coverage. One Board of Directors and one Chief Executive Officer managed the new corporation.

In addition, the General Assembly of the State of Rhode Island enacted the Health Maintenance Organization Act of 1983, R.I. Gen.Laws §§ 27-41-1 *et seq.* (Supp. 1986), which was modeled after the federal HMO Act, 42 U.S.C. § 300e-9 (Supp.1986). Rhode Island is unique in the large percentage of employees covered by employer provided health plans. The State Act incorporates a dual choice provision which requires employers to offer a licensed qualified HMO as an employee choice for health insurance if an HMO provides services in the area where the employee resides. Blue Cross & Blue Shield challenged this dual choice provision as inconsistent with provisions of the federal Employee Retirement Income Security Act (ERISA). *See* 29 U.S.C. §§ 1001-1461 (Supp.1987). In *Blue Cross of R.I. v. Cannon*, 589 F.Supp. 1483 (D.R.I. 1984), the suit was dismissed because it was not ripe; however, it was noted that the employer's obligation to provide an HMO alternative is subject to the condition precedent of a request by an eligible HMO to be included in the health insurance offering.

As of the Spring 1986, Blue Cross & Blue Shield was faced with a serious competitive problem. While Blue Cross & Blue Shield lost approximately 30,000 of its 543,015 enrollees; Ocean State's enrollment exceeded the most optimistic expectations and had grown to 70,000. Blue Cross & Blue Shield's loss of enrollment was attributed to its increased premium rates and to its lack

of an HMO plan which would provide more coverage than traditional Blue Cross & Blue Shield.

Rates had to be increased because Blue Cross & Blue Shield was experiencing financial difficulties. Its cash reserves had dropped below the State law requirement, which requires Blue Cross & Blue Shield to maintain an available cash supply sufficient to pay all operating expenses and claims for not less than a 1½ month period. *See* R.I.Gen.Laws § 27-19-6 (Supp.1986). Payments of claims exceeded Blue Cross & Blue Shield's estimates and the amount of revenue generated through premiums was not sufficient to cover Blue Cross & Blue Shield's anticipated costs. Blue Cross & Blue Shield had to raise its premium rates. The increased rates further contributed to its loss of enrollment which further required higher rates to cover the losses due to enrollees dropping out.

Although Blue Cross & Blue Shield dominated the health care financing industry, the loss of enrollment created concern. There was conflicting testimony at trial about Blue Cross & Blue Shield's market share.

Plaintiffs claimed that Blue Cross & Blue Shield controlled 80% of the market. Defendant did not dispute that it was the largest health care cost insurer in Rhode Island, but would not agree that it controlled 80% of the market. Ocean State claimed that 656,650 persons in Rhode Island were eligible to procure private health coverage and that 543,015 persons selected Blue Cross & Blue Shield coverage. Therefore, according to Plaintiffs' calculations Blue Cross & Blue Shield's enrollment share was 82.7%.

Defendant downwardly adjusted this estimate of its market share by making three adjustments to the market share calculation. First, the estimated number of members covered under a family contract was reduced from 3.4 persons to 2.8 persons, which resulted in a 17.64% reduction of Blue Cross & Blue Shield's enrollment share.

Next, duplicate coverage was factored into the calculation. The Defendant had assumed that 12% of Blue Cross & Blue Shield's enrollees had duplicate coverage with another Blue Cross & Blue Shield plan and that 8% of Blue Cross & Blue Shield's enrollees had duplicate coverage with another company. Thus, adjustments to the market reduced Blue Cross & Blue Shield's market share to 62.8%. Finally, Blue Cross & Blue Shield assumed the Rhode Island employment base was 10% greater than reflected in the Rhode Island population count because more workers came into the State to work than left the State to work. So Blue Cross & Blue Shield estimated that the total population eligible to select Blue Cross & Blue Shield coverage was 722,315 persons (the Rhode Island population 656,650 + the non-state resident workers 65,665). With the foregoing adjustments, Blue Cross & Blue Shield's market share was 57.1%. The Defendant, although it disputed the Ocean State estimate of Blue Cross & Blue Shield's market share, agreed that it had a substantial share of the market. This was an admission of the obvious. Blue Cross & Blue Shield is clearly the major provider of private health care cost payment in Rhode Island and thus it is the major factor in the competitive market. It clearly had market power. The issue here is whether or not it exercised that power unlawfully.

Both Blue Cross & Blue Shield and Ocean State were experiencing financial problems at about the same time during the Spring and Summer of 1986. Blue Cross & B'ue Shield was facing enrollment losses and increased premiums; while Ocean State's operating costs were exceeding its income. Both Ocean State and Blue Cross & Blue Shield had to make changes and adopt new programs. Blue Cross & Blue Shield responded with the prudent buyer policy, adverse selection, and HealthMate. Ocean State went through a major reorganization, increased the amount of payment subscribers were required

to pay for services rendered, and created a program called Specialty Incentive Pools (SIPS).

In May 1986, the Blue Cross & Blue Shield's Board of Directors approved a three prong approach to deal with Blue Cross & Blue Shield's loss of enrollment and financial difficulties. The plan included (1) implementing the "prudent buyer policy," (2) instituting "adverse selection rating factors" and (3) marketing of a new product, which was ultimately called "HealthMate." Blue Cross & Blue Shield submitted a series of riders to the classic hospital and medical service plans to the Department of Business Regulations (DBR), State of Rhode Island for its approval. The DBR approved the new HealthMate product, which was known as the "Z Plan," "Maps Plus," and 'Plan 100 Plus.' HealthMate provided 15% more coverage than standard Blue Cross & Blue Shield. It included hospital and medical service plans plus other coverage such as office visits, prescription drugs, student rates, and 'good health' benefits. Under HealthMate, subscribers must use participating physicians otherwise the plan would not pay for physician services. In addition, all Blue Cross & Blue Shield participating physicians are required to provide services under HealthMate and to accept the HealthMate payment as payment in full if they wished to remain Blue Cross & Blue Shield participating physicians.

HealthMate was first offered to employees of the State of Rhode Island in July 1986. This is the largest single group of employees covered by an employer health plan in Rhode Island, and no doubt, that fact prompted the creation of HealthMate. The Department of Administration, the State agency which awarded contracts for health coverage, extended its open enrollment season for selecting a health plan so that HealthMate could be offered. Later, HealthMate was offered to other experience rated groups. HealthMate was never offered alone as a health insurance plan, but was only marketed as an alternative

to traditional Blue Cross & Blue Shield if a competing HMO was also being considered as a health insurance option. Today, HealthMate is offered to all employer groups with more than 50 employees.

HealthMate was marketed with financial incentives for employers. If the employer paid the full cost of its employees' health insurance, HealthMate was offered at the same rates as traditional Blue Cross & Blue Shield. If employees were required to contribute to their coverage, then HealthMate was offered at 5% below the cost of traditional Blue Cross & Blue Shield. Ocean State claimed that between June 1986 and August 1987, it lost profits of $58,550 because of the head to head marketing and low cost of HealthMate. In addition, Ocean State estimated a $59,041 future loss of profits through June 1988.

To support the tiered pricing for HealthMate and traditional Blue Cross & Blue Shield coverage, Blue Cross & Blue Shield approved an adverse selection policy on June 1, 1986. Blue Cross & Blue Shield implemented the adverse selection policy without approval from the Department of Business Regulation (DBR). In October 1986, DBR ordered Blue Cross to cease using the adverse selection policy until it obtained DBR approval. On November 12, 1986, the DBR approved the adverse selection factors and Blue Cross resumed use of the adverse selection policy.

Blue Cross & Blue Shield was concerned that it would be adversely selected by subscribers if other health plans were offered. "Adverse selection" is jargon which means exactly the opposite of what it says. It has nothing to do with selection of Blue Cross. It is the opposite, the selection of a competitor by a Blue Cross subscriber. It means that Blue Cross & Blue Shield was concerned that it would lose its best (least expensive) members. It was concerned that it would lose a large percentage of its younger healthier subscribers to a different company

with a more comprehensive preventive health plan and be left with an older, less healthy population, causing its claims costs per subscriber to increase. Thus to reflect this possible increase in cost per subscriber, adverse selection factors were applied.

Under the adverse selection policy, employers were offered three different rates for Blue Cross & Blue Shield indemnity coverage. Employers would be charged the lowest rate if the employer only offered traditional Blue Cross & Blue Shield coverage. If the employer offered traditional Blue Cross & Blue Shield, a competing HMO and HealthMate, then the rate for traditional Blue Cross & Blue Shield would be at a middle level. If an employer offered traditional Blue Cross & Blue Shield and a competing HMO but refused to offer HealthMate, then the highest rate for traditional Blue Cross & Blue shield coverage would be charged.

Adverse selection rate differentials were determined based on a formula which Blue Cross & Blue Shield designed. The formula incorporated two estimates. The first estimate was called the health factor, which concluded that HMO enrollees, on the average, would be 22% healthier (22% less expensive) than the aggregate membership of the employed group.

The second estimate in the adverse selection calculation was Blue Cross & Blue Shield's estimate of the number of subscribers that might enroll in competitive health plans. The estimate was not based on Blue Cross & Blue Shield's prior experience of subscribers switching health coverage but on Blue Cross & Blue Shield's projection. Ocean State contended that Blue Cross & Blue Shield overestimated the number of subscribers who would be lost to competing HMOs, causing the adverse selection calculation to be higher than what was necessary to ensure that its premiums reflected its costs.

In February 1987, the Department of Business Regulations (DBR) released a study of the number of Blue

Cross & Blue Shield enrollees that switched to HMOs. It found that fewer enrollees dropped traditional Blue Cross & Blue Shield coverage and replaced it with HMO coverage than Blue Cross & Blue Shield had projected. Many employers complained to DBR about the substantial increase in their premiums, partly due to the adverse selection factors, and they threatened to discontinue Blue Cross & Blue Shield coverage. In February 1987, Blue Cross & Blue Shield decided to base its calculation of losses to competing HMOs upon actual lost enrollment. Thus, the second estimate factor in the adverse selection calculation was adjusted as of February 1987.

Ocean State asserted that the overestimate of loss of subscribers to competing HMO artificially increased price differential which discouraged employers from offering a competing HMO, such as Ocean State. Furthermore, Ocean State claimed that the rate differentials were designed to discourage employers from offering competing health insurance options, or alternatively to force employers to offer HealthMate if a competing health plan was an option.

Meanwhile, the financial circumstances of Ocean State were also under stress. As a new HMO, Ocean State decided in 1983 that it would withhold 20% of the physicians' fee until the end of the year at which time if Ocean State's operational expenses were in the black then the withholding would be paid to the physicians. This was seen as an incentive to its contracted physicians to keep health care costs low. In 1984 Ocean State returned the withhold to physicians. In 1985, however, Ocean State retained the withhold because cost of operating exceeded Ocean State's estimates. This action occurred in 1986.

Ocean State memberships had risen astronomically, but the rate of increase began to level off. In the spring and summer of 1986, it began to experience financial concerns not different from those of Blue Cross & Blue

Shield. Ocean State initiated a drastic management change on July 1, 1986, and designed new incentives for physicians to maintain costs. Not coincidentally, these initiatives were roughly coincident with Blue Cross's trilogy of programs, HealthMate, adverse selection and prudent buyer.

In an effort to control expenses and hopefully to provide a dividend to its physician members, Ocean State implemented the Speciality Incentive Pools (SIPs) as of November 1, 1986. Speciality Incentive Pools is another instance of jargon. It simply means that the physician would be paid his or her full charge rather than only 80% of the charge, if there was enough money left in the pool at the end of the year to do so. Ocean State divided participating physicians into specialty categories. Each specialty was allotted a certain sum of money as its operating budget. Physicians were paid 80% of their charges. If expenses for the specialty category did not exceed estimated operational cost, then the remaining funds in the specialty category would be divided among physicians in that group. Each specialty group had a very good reason to provide services at the lowest cost; thus, the name Speciality Incentive Pools. The 1986 operational cost exceeded Ocean State's estimates. Therefore, nothing additional was paid to participating physicians through the Speciality Incentive Pools.

Blue Cross & Blue Shield expressed concern that physicians were giving greater discounts to Ocean State than to Blue Cross & Blue Shield. In response to the March 25, 1986, decision of Ocean State to retain the 1985 withholdings, Blue Cross & Blue Shield announced the prudent buyer policy on June 6, 1986. The policy, however, did not become effective until November 1, 1986.

Prudent buyer is more jargon. What it means is that Blue Cross & Blue Shield would not pay more to a physician than what the physician was willing to accept for performing the same services for another health care

cost provider, including Ocean State. Thus, if physicians were accepting 80% of their charges as payment in full from Ocean State, then Blue Cross would also pay only 80% of physicians charges, as payment in full. Plaintiffs asserted that the prudent buyer policy was fashioned after Blue Cross & Blue Shield's hospital participation policy. Under that policy Blue Cross & Blue Shield participating hospitals who offered competitors discounts, which were comparable or better than the approximate 13% discount provided Blue Cross & Blue Shield, were threatened with termination of their status as participating providers. The hospital participation policy had been successfully implemented and permitted Blue Cross to buy hospital services at the lowest rate.

Under the prudent buyer policy, Blue Cross & Blue Shield would not pay more for physician services than the lowest payment the physician accepted for such services. At trial Blue Cross & Blue Shield contended that it was only trying to get the best price for its subscribers. Blue Cross & Blue Shield required physicians to document that the fees the physicians charged Blue Cross & Blue Shield were the lowest that the physicians charged for that particular service. If a physician failed to document by September 15, 1986 that he or she was not charging Blue Cross & Blue Shield more than he or she was charging its competitors, then Blue Cross & Blue Shield reduced its reimbursement to the physician by 20%. There was evidence that Blue Cross & Blue Shield understood the ramifications of the prudent buyer policy. A handwritten note by a Blue Cross & Blue Shield management employee stated that "not one guy in the state isn't going to know the implication of signing with Ocean State." Plaintiffs made much of this observation.

Plaintiffs contended that approximately one-third of Ocean State's participating physicians resigned from Ocean State as a result of the prudent buyer policy. Testimony was, however, that physicians resigned for many reasons. Some physicians claimed they resigned

because they were concerned about the effect of the prudent buyer policy upon their Blue Cross & Blue Shield patients. Others claimed that they could not afford to have their Blue Cross & Blue Shield payments cut by 20%. It is clear that some physicians resigned from Ocean State because of the prudent buyer policy, but is also abundantly clear that the actual number was far less than that contended by Ocean State.

Because about 350 of its 1200 participating physicians resigned, Ocean States claimed that it had to pay for the services of more non-participating physicians in order to provide physician services to its members at a level comparable to the level which existed before the physicians resigned. Although the physicians resignations represented a cross section of specialties, Ocean State contended that certain specialties were harder hit, such as cardiac surgery. Thus, Ocean State had to buy more services from non-participating physicians, which was more expensive. As a result, Ocean State contended that it incurred greater cost for providing physician services to subscribers. Therefore, Ocean State claimed that due to the prudent buyer policy, it had to pay an additional $946,260 to non-participating physicians between January 1987 and March 1987.

In addition, Ocean State contended that the reduction of participating physicians caused a reduction of subscribers. There was testimony that some subscribers dropped Ocean State when their personal physicians resigned from Ocean State. Ocean State would not pay the physician for services rendered to the patient and the patient would have to pay the physician without reimbursement from Ocean State. Ocean State claimed it lost $597,016 in profits on enrolled members who dropped Ocean State between November 1986 and August 1987.

Ocean State presented evidence that under the prudent buyer policy, Blue Cross & Blue Shield withheld more than $1,900,000 from Ocean State's 1200 participating

physicians. The certified class, however, included an estimated 900 physicians. During the time between implementation of the prudent buyer policy and the class certification, more than 300 physicians resigned from Ocean State. Those physicians who had prudent buyer withholds but were not participating physicians of Ocean State in April 1987 did not meet the definition of the class certification. The certified class of physicians claimed Blue Cross & Blue Shield withheld $1,425,000 from it.

Blue Cross & Blue Shield acknowledged that under the prudent buyer policy between January 1, 1987 and May 30, 1987 it withheld $2,058,169.58. During this period, providers requested $682,351.36 in refunds. Blue Cross & Blue Shield estimated that the refund payments would be $136,470.27 per month. Blue Cross & Blue Shield estimated that it would withhold $2,838,199.34 between November 1, 1986 and June 30, 1987. The refund estimates for this eight month period were $1,091,762.17. Thus, Blue Cross & Blue Shield's projected prudent buyer savings during this eight month period would be $1,746,-437.17.

Blue Cross & Blue Shield contended that the prudent buyer policy, adverse selection policy, and the marketing of HealthMate were exercises of good business judgment. Blue Cross & Blue Shield asserted that Ocean State's financial loss were due to both its being a young HMO and mismanagement. There was testimony that all young HMOs lost money in the initial years. Between June and July 1986, Ocean State attempted to reduce financial losses by switching its underwriters to United HealthCare, reducing the management fee, replacing its Chief Executive Officer, and instituting co-payments for office visits. There was conflicting testimony whether those changes were sufficient to put Ocean State in the black. Blue Cross & Biue Shield contended that between June 30, 1986 and September 30, 1986, Ocean State had profits

of $227,123. It contended that by the end of 1986, Ocean State's profits were $698,348. Thus, Blue Cross & Blue Shield claimed that adverse selection, HealthMate, and the prudent buyer policy did not cause Ocean State to lose money. Ocean State, however, asserted that those figures were deceptive and did not accurately reflect the impact of Blue Cross & Blue Shield's actions.

Ocean State claimed that it incurred a $809,158 loss involving hospital discounts between January 1984 through May 1986; a $597,016 loss of profits on enrolled members who terminated their coverage with Ocean State between November 1986 and August 1987; a $117,-591 loss of potential profits on possible state employee enrollees who did not contract with Ocean State due to the State of Rhode Island's contract with Blue Cross which offered HealthMate, between June 1986 and June 1988. Ocean State asserted that it lost $173,013 from expected profits which failed to materialize because of Blue Cross's actions. Thus, Ocean State claimed it lost a total of $1,696,798 due to Blue Cross's anticompetitive actions. The physicians class claimed it lost $946,760 between January 1987 and March 1987 due to Ocean State's payments to non-participating physicians and $1,900,000 due to the prudent buyer policy. They claimed a total loss of $2,846,260. The jury verdicts, however, awarded $947,000 to Ocean State and $1,746,437 to the Plaintiff class of physicians.

The jury's verdicts in this action are at variance with the proof. On the third try, after a jury had been returned to the jury room twice for reconsideration of its verdict, the jury returned a verdict for Plaintiffs on its Section 2 Sherman Act claims, but failed to award any damages. The jury awarded damages against Blue Cross & Blue Shield on the claims of intentional interference with advantageous relationships on behalf of Ocean State in the amount of $947,000 compensatory damages and $250,000 punitive damages and for the class of physi-

cians in the amount of $1,746,437 in compensatory damages.

The jury deliberated two days before returning a verdict finding Blue Cross & Blue Shield "Guilty" on both counts, the Section 2 Sherman Act violation and the common law tort of interference with advantageous relations. Initially, the jury awarded each Plaintiff, Ocean State and the class physicians, compensatory damages of $2,693,437 (not coincidentally $1,746,437 + 947,000) and punitive damages of $250,000. Ocean State and the class of physicians suffered different injuries and damages. It was thus highly unlikely that each Plaintiffs' award for damages would be exactly the same. Recognizing that more than mere coincidence could be a factor, the Court explained the purpose of each verdict form and that the jury must award damages separately for each Plaintiff and for each claim based on the evidence.

After further deliberation, the jury returned the second set of verdict forms. It again found Blue Cross & Blue Shield "Guilty" as to both the antitrust claims and the interference with contractual relationships claims brought by Ocean State and the class of Physicians. On the verdict form for *Ocean State v. Blue Cross & Blue Shield*, the jury listed compensatory damages of $947,000 and punitive damages of $250,000. On the verdict form for the class of physicians, the jury listed compensatory damages of $1,746,437. Neither of the second set of verdict forms stated whether the awards was for damages on the antitrust claim or for interference with contractual relationships claim or both. The jury was then instructed that the verdict must clearly state the specific claims upon which it awarded damages.

After further deliberation, the jury returned its third set of verdict forms. The total amount of the damage awards equaled the same amount as the second verdict forms. The verdict form for *Ocean State v. Blue Cross & Blue Shield* stated that as to the Section 2 of Sherman

Act claim, Blue Cross & Blue Shield was guilty but awarded no damages. As to the interference with contractual relationships, the jury found Blue Cross & Blue Shield guilty and awarded Ocean State compensatory damages of $947,000 and punitive damages of $250,000. On the verdict form for the *Class of Physicians v. Blue Cross & Blue Shield*, the jury found Blue Cross & Blue Shield guilty of the Section 2 of the Sherman Act claim, but awarded no damages. On the interference with contractual relationships claim, the jury found Blue Cross & Blue Shield guilty and awarded the class of physicians compensatory damages of $1,746,437.

The Defendant contends that the compensation award to Ocean State is based on the Plaintiffs' Exhibit 776 (for identification) prepared by one of Plaintiffs' damages expert and used by her as a basis for her testimony. In this the Defendant is clearly correct. Exhibit 776 is a three column simulated spreadsheet. The headings for the columns were lost profits, (Ocean State) lost hospital discounts, (Ocean State) and lost payments for the physicians' class. Under the heading lost payment to the physicians' class was a subsection entitled payments by OSPHP to non-participating physicians 1/87—3/87. This section reported $946,260 payments Ocean State made to non-participating physicians between January 1987 and March 1987. Plaintiffs' evidence is that $946,260 represents payments by Ocean State to "Non-Participating Physicians 1/87—3/87 $946,260." The jury simply rounded to the next nearest thousand the $946,260 payment to non-participating physicians to arrive at the $947,000 and erroneously awarded it to Ocean State.

The payment Ocean State made to non-participating physicians between January and March 1987, was not a loss to Ocean State. This much the Plaintiffs must concede because they themselves claim this loss for the class of physicians. This money would have been returned to participating physicians. Ocean State budgeted the

$946,260 to the Speciality Incentive Pools (SIP's). Ocean State was required to pay the $946,260 to either the physicians in the SIPS pools if the Speciality Incentive Pools' costs were less than the amount budgeted or if the Speciality Incentive Pools' costs exceeded Ocean State's estimates, then the $946,260 would have been used to reduce the Speciality Incentive Pools' excess costs. Either way, Ocean State itself could not have lost money because of payments to physicians who were not Ocean State participating physicians. The losses due to Ocean State's payments to non-participating physicians was suffered by Ocean State participating physicians. They would have received the $946,260, if Ocean State had not had to pay that amount to non-participating physicians.

The Defendant also contends that the compensatory damages award to the certified class of physicians is based on another Plaintiffs' Exhibit, Plaintiffs' Exhibit 563. Exhibit 563 was an in house Blue Cross & Blue Shield document dated June 30, 1987 and entitled projected prudent buyer savings. Blue Cross & Blue Shield estimated that the prudent buyer policy would save a net amount of $1,746,437.17 over an eight month period. It appears that the jury rounded the $1,746,437.17 by omitting the 17 cents and based its awarded to the class of physicians on the amount of money Blue Cross & Blue Shield intended to save with the prudent buyer policy.

Exhibit 563 is Plaintiffs' evidence of the amount of money Blue Cross & Blue Shield expected to save due to the prudent buyer policy. It, however, does not indicate the damages the certified class of physicians incurred as a result of Blue Cross & Blue Shield's interference with their contractual relationships. The class was composed of physicians who were under contract to Ocean State and were also reimbursed by Blue Cross & Blue Shield. The witheld payments were payments Blue Cross & Blue Shield did not make to Blue Cross & Blue Shield physicians. Ocean State contracted physicians therefore had

no right to receive the withheld payments, except if they also participated in Blue Cross & Blue Shield and their payments had been reduced by Blue Cross & Blue Shield. Since Blue Cross & Blue Shield had many more participating physicians than Ocean State, there is no basis to conclude, as the jury did, that the withheld payments belonged to Ocean State physicians who were reimbursed by Blue Cross & Blue Shield. It is inappropriate to conclude that the certified class of physicians must have incurred losses equal to Blue Cross & Blue Shield's prudent buyer savings.

DISCUSSION

Standard of Review

In actions which blend claims for both legal relief in terms of monetary damages and equitable relief by way of injunction, a jury shall first determine the issue of damages. *Beacon Theatres, Inc. v. Westover*, 359 U.S. 500, 79 S.Ct. 948, 3 L.Ed.2d 988 (1959); *Dairy Queen, Inc. v. Wood*, 369 U.S. 469, 479, 82 S.Ct. 894, 900, 8 L.Ed.2d 44 (1962); *Wallace Motor Sales v. American Motor Sales Corp.*, 780 F.2d 1049, 1066 (1st Cir. 1985). The effect of a jury's determination as in this instance is significant. Here the jury returned a verdict that the Defendant Blue Cross & Blue Shield was guilty of violating Section 2 of the Sherman Act (15 U.S.C. § 2). The jury declined, after three attempts, to assess monetary damages. Generally speaking, it has been held that since the legal issues are to be heard first in an action under Section 2 of the Sherman Act (15 U.S.C. § 2), findings by the jury in the damages action, also involved in the application for equitable relief, are binding upon the trial court in its later consideration of the facts involved in equitable relief applications. *Florists' Nationwide Tel. Del. Net. v. Florists' Tel. Del. Assn*, 371 F.2d 263, 271 (7th Cir.) *cert. denied*, 387 U.S. 909, 87 S.Ct. 1686, 18 L.Ed.2d 627 (1967); *Calnetics Corp. v. Volkswagen of*

America, Inc., 532 F.2d 674, 690 (9th Cir.), *cert. denied*, 429 U.S. 940, 97 S.Ct. 355, 50 L.Ed.2d 309 (1976).

Indeed, the parties in this action, although in disagreement on almost every issue, seem to be in agreement on this aspect, to the effect that this Court is bound by the jury's determination of the factual issues. Thus, Plaintiffs are able to assert that the jury has concluded that Defendant's business practices of the prudent buyer policy, selective marketing of Healthmate, and its adverse selection policy were anti-competitive and illicit activity contrary to the purpose of the Sherman Act to provide competition, and, that these determinations bind this Court. Of course, Blue Cross & Blue Shield argues that since no damages were awarded, Plaintiffs have failed to prove injury, and therefore, the Sherman Act counts fail. However, before the Court determines to what extent it is bound by the findings of the jury, it will first determine if the jury verdict is supported by the evidence at all.

The standard of review in setting aside a jury verdict is narrow. In determining the motion for judgment notwithstanding the verdict, the Court must evaluate the evidence in the light most favorable to Plaintiffs. *Rios v. Empresas Lineas Maritimas Argentinas*, 575 F.2d 986, 989 (1st Cir. 1978). But the plaintiffs are not entitled to unreasonable inferences based on speculation and conjecture. *See Carlson v. American Safety Equip. Corp.*, 528 F.2d 384 (1st Cir. 1976); *Schneider v. Chrysler Motors Corp.*, 401 F.2d 549, 555 (8th Cir. 1968). A motion for judgment notwithstanding the verdict should be granted ". . . when as a matter of law, no conclusion but one can be drawn." *CVD, Inc. v. Raytheon Co.*, 769 F.2d 842, 849 (1st Cir. 1985) (citing *United States v. Articles of Drug Consisting of the Following*, 745 F.2d 105, 113 (1st Cir. 1984), *cert. denied sub nom.*, 470 U.S. 1004, 105 S.Ct. 1358, 84 L.Ed.2d 379 (1985)), *cert. denied*, 475 U.S. 1016, 106 S.Ct. 1198, 89 L.Ed.2d 312 (1986).

Therefore a motion for judgment notwithstanding the verdict should be denied if after reviewing the evidence in the light most favorable to the plaintiffs and drawing all reasonable inferences in their favor, there is sufficient evidence to support the verdict. *Engine Specialties, Inc. v. Bombardier Ltd.*, 605 F.2d 1, 9 (1st Cir. 1979), *cert. denied*, 446 U.S. 983, 100 S.Ct. 2964, 64 L.Ed.2d 839 (1980); *CVD, Inc.*, 769 F.2d at 849. A jury verdict supported by the evidence may not be set aside simply because the judge would have reached a different result. *See Coffran v. Hitchcock Clinic, Inc.*, 683 F.2d 5, 6 (1st Cir.), *cert. denied*, 459 U.S. 1087, 103 S.Ct. 571, 74 L.Ed.2d 933 (1982).

The standard of review for granting a new trial is not as stringent as for granting a judgment withstanding the verdict. But the trial judge may not set aside a verdict simply because he or she would have reached a different verdict. *Borras v. Sea-Land Serv., Inc.*, 586 F.2d 881, 887 (1st Cir. 1978). In granting a motion for a new trial the judge must find that "the verdict is against the clear weight of the evidence, or is based upon evidence which is false, or will result in a clear miscarriage of justice." *Milone v. Moceri Family, Inc.*, 847 F.2d 35, 37 (1st Cir. 1988); *see CVD, Inc.*, 769 F.2d at 848 (citing *Coffran* 683 F.2d at 6).

The Court will first determine whether there is sufficient evidence to support the jury verdict on the antitrust claims and the claims for the interference with contractual relationships. Then the Court will address the applications for injunctive and declaratory relief.

ANTITRUST CLAIMS

With respect to the Defendant's motion for judgment n.o.v. on the antitrust claims, it asserts two legal theories. First, the Defendant contended that the jury's findings of "no damages" for the antitrust claims indicated that no injury resulted to Plaintiffs' business or property as a

result of antitrust violations. Thus, it contends no liability arose for a private damage action under the Clayton Act, Section 4. 15 U.S.C. § 15 (Supp. 1988). Noting that the Plaintiffs suffered no injuries as a result of the Defendant's conduct, Defendant concludes that Plaintiffs failed to prove all elements of an antitrust violation and requested the Court to enter judgment in its favor on the Sherman Act Section 2 claims.

Defendant's argument warrants some attention as a ground for granting Defendant's motion for judgment notwithstanding the verdict on the antitrust claims. Plaintiffs filed this action seeking treble damages under Section Fifteen of the Sherman Act, 15 U.S.C. § 15. (Supp. 1988). It is a remedial provision of the Sherman Act. *See Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 485, 97 S.Ct. 690, 695, 50 L.Ed.2d 701 (1977). It frequently has been called the private attorney general provision of the antitrust laws because a private Plaintiff rather than the government may maintain an action for an alleged antitrust violation. *See, e.g., Hawaii v. Standard Oil Co.*, 405 U.S. 251, 262, 92 S.Ct. 885, 891, 31 L.Ed.2d 184 (1972); *Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100, 131, 89 S.Ct. 1562, 1580, 23 L.Ed.2d 129 (1969); *United States v. Borden Co.*, 347 U.S. 514, 518, 74 S.Ct. 703, 706, 98 L.Ed. 903 (1954). Section Fifteen of the Sherman Act, more commonly known as Section Four of the Clayton Act, provides that a Plaintiff can recover threefold the damages he sustains and the cost of the suit, including attorney's fees if the Plaintiff shows an injury in his business or property by reason of anything forbidden in the antitrust laws. *See* 15 U.S.C. § 15 (Supp. 1988). So for Plaintiffs to prevail on their antitrust claims, they must prove ". . . a violation [of the antitrust laws] and additionally show to a reasonable degree of certainty that there has been injury to them by reason of the violation." *See International Travel Arrangers, Inc. v. Western Airlines, Inc.*, 623 F.2d 1255, 1270 (8th Cir.), *cert. denied*,

449 U.S. 1063, 101 S.Ct. 787, 66 L.Ed.2d 605 (1980). To establish an antitrust violation, Plaintiffs must show that Blue Cross & Blue Shield engaged in monopolization acts in violation of Section Two of the Sherman Act. Section Two of the Sherman Act defines the criminal violation of monopolization and its penalties. 15 U.S.C. § 2 (Supp. 1988). But the mere existence of a violation cannot support a private action under Section Four of the Clayton Act. *See Gray v. Shell Oil Co.*, 469 F.2d 742, 749 (9th Cir. 1972), *cert. denied*, 412 U.S. 943, 93 S.Ct. 2773, 37 L.Ed.2d 403 (1973). Plaintiffs must show that they suffered an injury to business or property as a result of the antitrust violation. *See Hawaii*, 405 U.S. at 262, 92 S.Ct. at 891. What constitutes an injury to business or property is less than clear. The words "business or property" refer to commercial interest. *See id.* at 264, 92 S.Ct. at 892. However, injury to business or property is defined in terms of a tautology. Since Section 4 of the Clayton Act provides a money damages remedy, it must be an injury which the jury is able to quantify in dollars. It is the kind of injury that the antitrust laws were designed to prevent, namely damage as a result of anticompetitive conduct. *See Brunswick Corp.*, 429 U.S. at 489, 97 S.Ct. at 697. Plaintiffs do not have to prove that the antitrust violation was the sole cause of the injury. *See Zenith Radio Corp.*, 395 U.S. at 114, 89 S.Ct. at 1571. But the Plaintiffs must show a causal relationship between the injury and the violation. *See id.* at 114 n.9, 89 S.Ct. at 1571-72 n.9. Furthermore, the Plaintiffs must prove some indication of the amount of damages. *See, e.g., Construction Aggregate Transport, Inc. v. Fla. Rock Indus.*, 710 F.2d 752, 782 (11th Cir. 1983); *Larry R. George Sales Co. v. Cool Attic Corp.*, 587 F.2d 266, 270 (5th Cir. 1979); *Terrell v. Household Goods Carriers' Bureau*, 494 F.2d 16, 20 (5th Cir.), *cert. denied*, 419 U.S. 987, 95 S.Ct. 246, 42 L.Ed.2d 260 (1974). Thus, "[t]o be 'liable' under the antitrust laws . . . means that one has to violate the antitrust laws and that violation

has resulted in an injury to the business or property of the plaintiff, *i.e.*, there was fact of damage." *Response of Carolina, Inc. v. Leasco Response, Inc.*, 537 F.2d 1307, 1320 (5th Cir. 1976).

The jury's award of no damages on the antitrust claims indicates that they found that the Plaintiffs were not damaged by an antitrust violation. The Court of Appeals for the District of Columbia confronted a similar situation. *See Association of Western Rys. v. Riss & Co.*, 299 F.2d 133, 134-35 (D.C.Cir) *cert. denied*, 370 U.S. 916, 82 S.Ct. 1555, 8 L.Ed.2d 498 (1962). There the jury returned a verdict against the Defendant but did not award any damages. *See id.* The Court of Appeals concluded that the verdict plainly meant that the Defendants conspired but that the conspiracy did not damage the Plaintiff. *See id.* at 135. As a result, the court held that Plaintiff had not proved its claim because it failed to show damages. *See id.*

In this matter, the jury's determination of no damages means exactly that. The Court must conclude that Plaintiffs failed to sustain their burden of showing damages to their business or property as a result of an antitrust violation. With this conclusion in mind, the result is preordained. Thus, Plaintiffs have not proved their treble damage antitrust claims and the Defendant is entitled to a judgment notwithstanding the verdict on those claims.

Defendant's second theory is that it is entitled to entry of judgment in its favor as a matter of law on the remaining antitrust claims. Blue Cross argues that there was insufficient evidence to establish antitrust violations because of the prudent buyer policy, selective marketing of HealthMate, and adverse selection policies. Therefore, the Defendant reasons that the Court is required to enter judgment in its favor as a matter of law. A more in depth analysis of prudent buyer, adverse selection, and the selective marketing of HealthMate is needed before

conclusions may be drawn on whether they separately or collectively violate antitrust laws.

First, Blue Cross contends that the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, exempted adverse selection and the selective marketing of HealthMate from the antitrust laws. The Defendant claims that adverse selection and HealthMate constituted the business of insurance regulated by state law; therefore, those programs were exempt under the Sherman Act. On the other hand, Plaintiffs claim health service corporations are not in the business of insurance so they are not eligible for the McCarran-Ferguson exemption to the antitrust laws. There is substantial support for the Plaintiffs' contention. *See Group Life & Health Ins. Co. v. Royal Drug*, 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979). There is respectable authority to the contrary. *See Health Care Equalization Comm. v. Iowa Medical Soc'y*, 851 F.2d 1020 (8th Cir.1988). However, as it is made clear hereafter there is no need to presently resolve this conflict.

The question is whether or not the prudent buyer policy, adverse selection and the selective marketing of HealthMate violate antitrust laws. Plaintiffs must prove the following elements by a preponderance of the evidence:

> First, that the Defendant had monopoly power in a relevant market;
>
> Second, that the Defendant willfully acquired or maintained that power through restrictive or exclusionary conduct;
>
> Third, that Defendant's activities occurred in or affected interstate commerce; and
>
> Fourth, that Plaintiff was injured in its business or property because of Defendant's restrictive or exclusionary conduct.

See, e.g., United States v. Grinnell Corp., 384 U.S. 563, 570-71, 86 S.Ct. 1698, 1704, 16 L.Ed.2d 778 (1966); *Forro Precision, Inc. v. Intern. Business Mach. Corp.*, 673 F.2d 1045, 1058 (9th Cir.1982); *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 272-76 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093, 100 S.Ct. 1061, 62 L.Ed.2d 783 (1980).

The terms "monopoly power" and "market power" are generally used interchangeably. P. Areeda & D. Turner, *Antitrust Law*, § 529 at 388 (1978). "Monopoly power" is the power to control prices or exclude competition in a relevant market. *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 391, 76 S.Ct. 994, 1005, 100 L.Ed. 1264 (1956). The relevant market is the "area of effective competition" where the defendant operates. *Standard Oil Co. v. United States*, 337 U.S. 293, 299 n. 5, 69 S.Ct. 1051, 1055 n. 5, 93 L.Ed. 1371 (1949). Relevant market is identified by the product and its interchangeability plus the geographic area. *See Brown Shoe Co. v. United States*, 370 U.S. 294, 336-37, 82 S.Ct. 1502, 1530, 8 L.Ed.2d 510 (1962); *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 399, 76 S.Ct. 994, 1009, 100 L.Ed. 1264 (1956). Usually the trier of fact defines the relevant market. *See International Boxing Club, Inc. v. United States*, 358 U.S. 242, 245, 79 S.Ct. 245, 247, 3 L.Ed.2d 270 (1959).

Blue Cross contended that as between the class of physicians and Blue Cross they are not in the same relevant market. Physicians were not sellers of health insurance and therefore in reality are not head to head competitors of Blue Cross. Without a relevant market existing between Blue Cross and the class of physicians, Blue Cross claimed it could not engage in anticompetitive acts which could harm the class. The only effect if at all on the class due to Blue Cross's actions, it contends is indirect. In addition, Blue Cross hypothesized that even if it possessed 100% share of the health care financing

market, the physician class would not have any antitrust claim because it derives only a small portion of its income from Blue Cross insureds. Noting that physicians are paid from many sources including Medicare, Medicaid, commercial insurance carriers, self-insured employers, and patients directly, Blue Cross claims that there was no evidence that Blue Cross represented any more than 30% of the dollar purchases of physician services. Thus, it contends, it could not possess monopoly power and could not have engaged in anticompetitive conduct.

Defendants are confusing relevant market with standing to sue. It is not a requirement to an antitrust suit that plaintiff and defendant be in the same relevant market. *See Blue Shield of Va. v. McCready*, 457 U.S. 465, 478-81, 102 S.Ct. 2540, 2547-49, 73 L.Ed.2d 149 (1982). Plaintiff, however, must meet the standing requirement that it allege that it suffered an injury to its business or property as a result of the Defendant's conduct. *See* 15 U.S.C. § 15 (1982). The First Circuit requires that the persons injured by the alleged antitrust violation be within a target area, which draws a line and excludes persons whose injuries are too remote. *See Engine Specialties, Inc. v. Bombardier Ltd.*, 605 F.2d 1, 17-19 (1st Cir.1979).

The class of physicians have asserted an injury to their business or property as a result of the alleged antitrust violation, i.e. the loss of reimbursement from the SIP's pool because of payments to nonparticipating physicians. Their alleged injury is within the target area. Thus, the class of physicians have standing to sue even though they may not be participants in the same relevant market as Blue Cross & Blue Shield.

Blue Cross & Blue Shield acquired its market share before Ocean State's creation. The undisputed evidence is that Blue Cross & Blue Shield was for years essentially the sole private health care cost insurer in the State of

Rhode Island. Not only did Blue Cross & Blue Shield have a better "mousetrap," it had the only "mousetrap" in town. As time went on, the industry changed with the development of health maintenance organizations. Rhode Island Group Health Association (RIGHA) appeared in 1971. Its physicians were employed by RIGHA and a subscriber was required to select a RIGHA physician. This plan had some disadvantage from the point of view of the subscriber, who heretofore had been accustomed to free selection of his or her own physician. Ocean State was a natural progression of the Health Maintenance format. It entered into contracts with almost half the physicians in the State of Rhode Island, providing patients with a wider choice of their respective physicians. It is obvious that a natural tension would develop between Blue Cross & Blue Shield and Ocean State and that physicians would seek the continuance of both plans in order that they could contract with both plans. It is not without significance that it was not Blue Cross & Blue Shield customers who have complained. The Plaintiffs are Ocean State and some physicians. The market involved is a market which provides means to finance health care. There is no proof that competition for physician services has been affected, or that any payment to which a physician is entitled has been lost. The claim is that purchasers of health insurance have been corralled by Blue Cross & Blue Shield to the competitive disadvantage of its competitors. The genesis of this complaint is the response of Blue Cross & Blue Shield to market conditions and the circumstances extant in the spring, summer and fall of 1986.

Both Blue Cross & Blue Shield and Ocean State were facing difficult financial conditions in the spring of 1986. They were both losing money. The largest single contract involving the employees of the State of Rhode Island was due for competitive bids at the end of June 1986. At that time Ocean State had not been able to return the 20% it had retained from its contracted phy-

sicians for the calendar year 1985. Thus, Ocean State physicians, who had also contracted with Blue Cross charged 20% less to Ocean State than the same physicians had charged Blue Cross for precisely the same services. In this mix, Blue Cross & Blue Shield created its HealthMate plan, originally called "Z Plan", "MAPS Plus", and "PLAN 10 PLUS". Blue Cross & Blue Shield's market share permitted it to develop both the prudent buyer policy, adverse selection, and HealthMate.

"The connection between market share and market power if far from clear." *See* P. Areeda, *supra* at 328. Size alone does not violate the Sherman Act. *United States v. United States Steel Corp.*, 251 U.S. 417, 40 S.Ct. 293, 64 L.Ed. 343 (1920). Courts, however, must consider the market share of the alleged monopolist as an important factor in determining the existence of monopoly power. *See, e.g., United States v. Grinnell Corp.*, 384 U.S. 563, 570-71, 86 S.Ct. 1698, 1704, 16 L.Ed.2d 778 (1966); *American Tobacco Co. v. United States*, 328 U.S. 781, 797, 66 S.Ct. 1125, 1133, 90 L.Ed. 1575 (1946); *United States v. Aluminum Co. of America*, 148 F.2d 416, 424 (2d Cir.1945). In unregulated industries, courts measure market power by defining the relevant product and geographic market and compute the defendant's market share. *See Southern Pacific Communications v. American Tel. & Tel.*, 740 F.2d 980, 1000 (D.C.Cir.1984), (citing (*United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 391, 76 S.Ct. 994, 1005, 100 L.Ed. 1264 (1956)), *cert. denied* 470 U.S. 1005, 105 S.Ct. 1359, 84 L.Ed.2d 380 (1985). In a regulated industry, such as health care insurance, a heavy reliance on market share statistics probably would be an inaccurate or misleading indication of monopoly power. *See Southern Pacific Communications*, 740 F.2d at 1000; *MCI Communications Corp. v. American Tel. and Tel. Co.*, 708 F.2d 1081, 1107 (7th Cir.), *cert. denied*, 464 U.S. 891, 104 S.Ct. 234, 78 L.Ed.2d 226 (1983). Thus, the size of a regulated com-

pany's market share should be a point of departure in determining the existence of monopoly power. *Id.* at 1107. Other factors such as size of competitors, degree of barriers to entry, pricing trends and practices and technological superiority may be considered in determining market power. *See, e.g., United States v. E.I. du Pont de Nemours & Co.*, 96 F.T.C. 650, 762 (1980); *International Distrib. Centers, Inc. v. Walsh Trucking Co., Inc.*, 812 F.2d 786 (2d Cir.1987); *Fishman v. Estate of Wirtz*, 807 F.2d 520, 532-39 (7th Cir.1986). A monopoly power analysis must focus directly on the defendant's ability to control prices or exclude competition. *MCI Communications Corp.*, 708 F.2d at 1107. It is essential to also keep in mind the fact that the antitrust laws were enacted for the protection of competition, not competitors. *See Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488, 97 S.Ct. 690, 697, 50 L.Ed.2d 701 (1977) (citing *Brown Shoe Co. v. United States*, 370 U.S. 294, 320, 82 S.Ct. 1502, 1521, 8 L.Ed.2d 510 (1962)).

The evidence established that Blue Cross provides in Rhode Island private nongovernment health care financing for a major market share. It is not contended that because of Blue Cross & Blue Shield's dominant market position, it has charged its customers, the persons insured by Blue Cross & Blue Shield more than they should have been charged. There is no suggestion that Blue Cross & Blue Shield has not obtained the best economic benefit for its subscribers. Indeed, the complaint is at bottom that because of Blue Cross & Blue Shield's market power, it has been able to get a better deal for medical services than Ocean State and that because of its market power, physicians have the awful choice of yielding to its fee schedule or losing their patients who are Blue Cross & Blue Shield subscribers. At the same time the evidence is clear that Blue Cross & Blue Shield face intense competition from Ocean State and RIGHA. Also, insurance

companies with national bases are becoming more involved in the Rhode Island market. Large employers have become self insurers. Thus, although Blue Cross & Blue Shield has market power, it is not without limit. There is a competitive market. The argument goes that since so many persons are enrolled in Blue Cross & Blue Shield in the State of Rhode Island what it does must be considered in the context of its market power. So much is true. The question is did it use its obvious market power in an anti-competitive manner? *See, e.g., Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 105 S.Ct. 2847, 86 L.Ed.2d 467 (1985); *United States v. Grinnell Corp.*, 384 U.S. 563, 86 S.Ct. 1698, 15 L.Ed.2d 778 (1966); *Lorain Journal Co. v. United States*, 342 U.S. 143, 72 S.Ct. 181, 96 L.Ed. 162 (1951), *see also United States v. United Shoe Mach. Corp.*, 110 F.Supp. 295 (D. Mass.1953), *aff'd*, 347 U.S. 521, 74 S.Ct. 699, 98 L.Ed. 910 (1954).

What is anti-competitive activity is not a matter that has been clearly defined. There are some significant signposts along the way, but the route is not so clearly marked that departures are unavoidable. It is blandly stated that "[t]he use of monopoly power, however, lawfully acquired, to foreclose competition, to gain a competitive advantage, or to destroy a competitor, is lawful under the Sherman Act." 54 Am.Jur.2d § 42, at 692 (citing *Home Placement Service, Inc. v. Providence Journal Co.*, 682 F.2d 274 (1st Cir.1982), *cert. denied*, 460 U.S. 1028, 103 S.Ct. 1279, 75 L.Ed.2d 500 (1983)). But what is the anticompetitive behavior which must be condemned? Theorists have not done much to illuminate the essential elements. Thus, *Areeda* talks in terms of exclusionary conduct not competitive on the merits and not more restraint than reasonably necessary to maintain competition. *P. Areeda, supra* ¶ 655(b) n. at 72-73. Courts have adopted Areeda's definition of exclusionary conduct which includes "behavior that not only (1) tends

to impair the opportunities of rivals, but also (2) either does not further competition on the merits or does so in an unnecessarily restrictive way." *See, e.g., Aspen Skiing Co.*, 472 U.S. at 605, 105 S.Ct. at 2859 (citing 3 P. Areeda & D. Turner, *Antitrust Law* ¶ 626b at 78 (1978)); *Barry Wright Corp. v. ITT Grinnel Corp.*, 724 F.2d 227, 230 (1st Cir.1983) (citing 3 P. Areeda & D. Turner, *Antitrust Law* ¶ 626 at 83 (1978)); *Instructional Sys. Dev. Corp. v. Aetna Cas. and Sur. Co.*, 817 F.2d 639, 649 (10th Cir.1987) (citing 3 P. Areeda & D. Turner, *Antitrust Law* ¶ 625b (1978)).

It is crucial to differentiate "between practices which tend to exclude or restrict competition . . . [from practices that result from] the success of a superior product, a well-run business, or luck, on the other [hand]", the very essence of competition. *Aspen Skiing Co.*, 472 U.S. at 604, 105 S.Ct. at 2858. Examples of the effect of competition on the merits are non-exploitative pricing, higher output, improved product quality, energetic market penetration, successful research and development, and cost-reducing innovations. *See Aspen Skiing Co.*, 472 U.S. 585, 105 S.Ct. 2847; *United States v. Aluminum Co. of America*, 148 F.2d 416 (2d Cir.1945). Blue Cross & Blue Shield has historically been very successful. On the other hand, Ocean State's penetration of the market has been phenomenal. With these general principles in mind, the specific aspects of Blue Cross & Blue Shield's adverse selection, HealthMate, and prudent buyer policies must be examined.

Adverse selection is criticized because it is claimed that the number of subscribers who it was estimated would leave Blue Cross was too high. The obvious import of this circumstance would be to increase the cost of Blue Cross & Blue Shield. It is a curious argument indeed by a competitor that Blue Cross & Blue Shield was charging too much for its product. Competitors could hardly be injured by an increase in price. *Matsushita*

Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 583, 106 S.Ct. 1348, 1354, 89 L.Ed.2d 538 (1986). What is more significant is that no one disputes that adverse selection was a fact. Healthier persons would tend to enroll in an HMO. If they did so, then without doubt Blue Cross & Blue Shield would be left with more expensive subscribers. The dispute posited by Plaintiffs is that fewer subscribers would leave Blue Cross & Blue Shield than Blue Cross & Blue Shield estimated. This is hardly the basis of an antitrust claim. Certainly, business people have some area of reasonable and responsible legitimate judgment. This is such an instance.

HealthMate is the result of research and development which concluded that HMO's will have a major role in health care financing in the future. Although HealthMate is not an HMO, its was Blue Cross's attempt to provide a health care financing plan comparable to an HMO until Blue Cross could establish an HMO program. Antitrust laws support the introduction of new products, such as HealthMate, because it encourages competition. *See Berkey Photo, Inc.*, 603 F.2d at 263. If Blue Cross & Blue Shield were foreclosed by the Sherman Act from competing in an HMO format, the Plaintiff Ocean State would then have major HMO market share in Rhode Island. This use of the Sherman Act would produce obvious anticompetitive effects.

The selective marketing of HealthMate does not negate the policy reason for encouraging HealthMate. Offering HealthMate as an option to subscribers who are eligible for Ocean State, is head to head competition between Ocean State and Blue Cross and that competition benefits consumers by providing them with alternative health care financing options. It is only because of Ocean State's decision not to compete that the product is not offered elsewhere. Ocean State seeks, therefore, to benefit from its lack of competitive effort in areas where for reasons to its advantage it decides not to compete.

With respect to the prudent buyer program, Plaintiffs asserted that there was sufficient evidence to show that the prudent buyer program was exclusionary. They contended that the prudent buyer had the purpose and effect of maintaining the Defendant's monopoly power and was not a legitimate money saving policy. Noting the testimony of Ronald Battista, Senior Vice President of Professional Relations at Blue Cross & Blue Shield, that prudent buyer was not designed to produce savings for Blue Cross, Ocean State concluded that prudent buyer had an anticompetitive purpose. Relying on Blair Suellentrop's, Chief Executive Officer of Ocean State, testimony regarding the decline in Ocean State's enrollment and resignation of participating physicians, Ocean State concluded that the prudent buyer policy was instituted to harm Ocean State. Indeed, it was Ocean State who claimed that the testimony of Ronald Battista, Blair Suellentrop, and Douglas McIntosh, Chief Executive Officer of Blue Cross & Blue Shield, established sufficient evidence to show that the prudent buyer program was anticompetitive.

On the contrary, Mr. Battista's and Mr. McIntosh's testimony indicated that prudent buyer was instituted to assure that Blue Cross's payments to physicians were not more than Ocean State's payments to physicians. There was no evidence that securing comparable fees for physician services resulted in any anticompetitive effect or impaired Ocean State's competitive opportunities. That the policy had the effect of harming Ocean State was inevitable, but was from the point of view of the consumer clearly understandable. The harm that came Ocean State's way was the resignation of some of its physicians, and claimed increased costs. This harm has to do with the market for physicians' services and the election by physicians of a course which they considered most beneficial to their financial point of view. As a naked proposition, it would seem silly to argue that a policy to pay the same amount for the same services is

anticompetitive, even on the part of one who has market power. This, it would seem, is what competition should be all about.

Relying on *Kartell v. Blue Shield of Mass.*, Defendant claimed that prudent buyer was a legitimate defense under a "most favored nations clause" which was designed to protect Blue Cross from paying more for the same services than competitors. 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029, 105 S.Ct. 2040, 85 L.Ed.2d 322 (1985). Blue Cross analogized the prudent buyer policy of this case with the no balance billing policy in *Kartell*. *See id.* In *Kartell*, the First Circuit held that Blue Cross was a purchaser of health services and as such had the right to require participating physicians not to balance bill patients who are Blue Cross subscribers. *Id.* Blue Cross argued that as a purchaser of health services it has a lawful right to bargain with its suppliers, the physcians, for the best possible price terms. Blue Cross is a purchaser of health services. The more Blue Cross's activities resemble a purchaser the less likely that they are unlawful. *See id.* at 925 As a legitimate buyer, Blue Cross is entitled to use its market power to get the best price for the services it purchases. *See id.* at 929. Therefore, the prudent buyer policy is clearly not anticompetitive and does not violate the antitrust laws.

Indeed, if Plaintiffs are correct in their contention that the prudent buyer policy is anticompetitive, it is impossible not to come to the same conclusion regarding Ocean State's SIPS plan. There is no principle of antitrust law which would deny a business practice to any entity with market power and permit that practice on the part of competitor who does not have market power. To hold prudent buyer anticompetitive would have given and would give Ocean State an unfair competitive advantage in the market, a result which is antithetical to the purpose of the Sherman Act and economically detrimental to health care consumers.

The Defendant's motion for a judgment notwithstanding the verdict is granted on the antitrust claims. The adverse selection programs, prudent buyer program, and the selective marketing of HealthMate are not anticompetitive and do not violate the antitrust laws. There can be no conclusion other than that these programs benefit consumers and represent legitimate responses to competitive conditions.

ADDITUR·

The physicians' class seeks a $1.9 million dollar additur on the antitrust claim. Relying on the testimony of Thomas Aman and Ronald Battista, Defendant's witnesses, who both testified that Blue Cross retained at least $1,900,000 from Ocean State participating physicians and the physicians' class who claimed that Blue Cross retained $1,900,000 from Ocean State participating physicians, Plaintiffs concluded that there was no valid dispute concerning the Blue Cross withhold. Therefore, the $1,900,000 that Blue Cross withheld may be considered as the damage for the antitrust violation. In light of the jury's verdict and the Court's determination of the Defendant's motion for judgment not-withstanding the verdict on the antitrust claim, Plaintiffs' motion for additur must be denied.

INTERFERENCE WITH CONTRACTUAL RELATIONSHIPS

Next, it is necessary to determine whether the prudent buyer, adverse selection, or the selective marketing of HealthMate interfere with the contractual relationships between Ocean State and its participating physicians. Plaintiffs claimed that Ocean State and the class of physicians incurred damages under their contracts due to the Defendant's actions. Ocean State argued that its advertising budget had to be increased beyond what it expected to spend and above the average advertising expenditures for HMO of its size. Ocean State claimed it

incurred additional advertising expenses of $335,000 due to Blue Cross & Blue Shield's actions and the subsequent negative publicity. In addition, Ocean State claimed that it lost profits of $173,013 because prospective members did not enroll due to the Defendant's actions. Ocean State, also, contended that it incurred unbudgeted expenses of up to $1,053,740 to retain physicians in certain specialties. The jury did not award any of these claimed damages to Ocean State.

The class of physicians claimed that the money Blue Cross & Blue Shield withheld caused the class to suffer damages. In addition, plaintiffs contended that the class of physicians lost $946,760, which represented the additional moneys Ocean State paid to non-participating specialists. These damages were erroneously awarded to Ocean State.

Defendant claimed that it did not interfere with Ocean State's contractual relationships with the class of physicians. It asserted that there was no evidence that any act by Blue Cross & Blue Shield made more difficult the performance of the Ocean State contracts or lessened their value. Blue Cross & Blue Shield, also, contended that the class' contracts were not terminated, breached, or altered in any sense.

The Defendant argued that the jury awards on the interference with contractual relationships were not based on evidence. Furthermore, Defendant claimed that the $947,000 the jury awarded Ocean State represented lost payments to the physicians' class and that Ocean State never claimed that amount as its damages. Therefore, the Defendant contended that the evidence does not support an award of $947,000 to Ocean State.

Blue Cross & Blue Shield argued that the $1,746,487 awarded to the class of physicians represented Blue Cross & Blue Shield's estimated savings through the prudent buyer plan for an eight month period. It did not repre-

sent the damages to the class of physicians. The Defendant's contentions have substantial basis. Although the class claims that the $1,746,437 equals its damages the class ignores the fact that many physicians who are not in the class were among those from whom full payment was withheld. The Defendant further contends that there was no evidence from which a reasonable jury could award any damages.

The Rhode Island Supreme Court defined the basic elements of a claim for tortious interference with contractual relationships in *Smith Dev. Corp. v. Bilow Enter. Inc.*, 112 R.I. 203, 211, 308 A.2d 477, 482 (1973). Later cases have adopted these elements for a claim of tortious interference with prospective contractual relationships. *See, e.g., Roy v. Woonsocket Inst. for Sav.*, 525 A.2d 915, 979 (R.I.1987); *Mesolella v. City of Prov.*, 508 A.2d 661, 670 (R.I.1986); *Federal Auto Body Works, Inc. v. Aetna Cas. & Sur. Co.*, 447 A.2d 377, 380-81 (R.I.1982). Plaintiff must prove by the preponderance of the evidence that a contract existed, that the alleged wrongdoer's interference was intentional, and that damages resulted from it. *Smith Dev. Corp.*, 112 R.I. at 211, 308 A.2d at 482. The Plaintiff must show that the Defendant intended to do harm without justification. *Mesolella*, 508 A.2d at 670. The Defendant has the burden of proving sufficient justification for an interference. *Smith Dev. Corp.*, 112 R.I. at 211, 308 A.2d at 482.

The Plaintiffs have met their burden of proving that contracts existed between Ocean State and Ocean State participating physicians and that Blue Cross knew of these contracts. The Plaintiffs, however, have failed to present any evidence that Blue Cross intentionally interfered with the contracts by implementation of the prudent buyer program, adverse selection, and the selective marketing of HealthMate. The only evidence was that some physicians perceived it to be to their economic ad-

vantage to terminate their relationship with Ocean State in accord with the terms of their agreement with Ocean State because of the prudent buyer policy. Translating this circumstance into an intentional interference by Blue Cross & Blue Shield with a contractual relationship is quite clearly absurd. Blue Cross & Blue Shield announced what it was willing to pay. Some physicians, not willing to give Blue Cross & Blue Shield a discount, resigned from Ocean State as permitted by their contract with Ocean State. There is no evidence of intentional interference with the contract between the class of physicians and Ocean State. Further, prudent buyer, adverse selection, and the selective marketing of HealthMate were justified courses of action that Blue Cross undertook as appropriate competition so that its subscribers would not be further burdened. Absent these programs, Blue Cross would pay more to the same physicians for their services than Ocean State. Blue Cross & Blue Shield would be subject to additional expense because of healthier subscribers transferring to an HMO because Blue Cross subscribers would lack a program comparable to Ocean State's coverage. It is obvious that Blue Cross acted with justification and therefore, the prudent buyer policy, adverse selection, the selective marketing of HealthMate were without doubt, justified responses to competitive conditions. Defendant's motion for judgment notwithstanding the verdict on the interference of contractual relationships must be and is granted.

Further, the jury verdict that Defendant was liable on the claim of tortious interference with contractual relationships was against the clear weight of the evidence that Blue Cross justifiably instituted the prudent buyer policy, adverse selection, and the selective marketing of HealthMate. Also, the damages awarded by the jury were inappropriate. A new trial is required to prevent injustice. Giving full respect to the jury's determination, the Court is left with the firm conviction that a mistake

has been committed in that damage amounts have been awarded to parties who are not entitled to them. Therefore, Defendant's motion for a new trial on the intentional interference with contractual relationships is also granted.

INJUNCTIVE RELIEF

Plaintiffs and Defendant seek injunctive relief. Plaintiffs move to enjoin Blue Cross from continuing the prudent buyer program or implementing a similar program and to restrain the marketing of HealthMate. The Defendant moves to enjoin the Plaintiff-Intervenors from engaging in the illegal practices alleged and to restrain the Physician and Surgeons Association of Rhode Island, Inc. from negotiating or attempting to negotiate collectively physician fees with Blue Cross.

Although Plaintiffs and Defendant seek equitable relief for different purposes, the burdens of proof are the same for each moving party. Congress enacted Section 16 of the Clayton Act to permit private actions for equitable relief. 15 U.S.C. § 26 (Supp.1988). Section 16 of the Clayton Act, reads in part: "[a]ny person . . . [or] corporation . . . shall be entitled to sue for injunctive relief . . . against threatened loss or damage by a violation of the antitrust laws . . . under the same conditions and principles as injunctive relief against threatened conduct that will cause loss or damage . . ." 15 U.S. § 26 (Supp. 1988). Injunctive relief is available to private parties when the traditional equity principles are met and there is a demonstration of a threatened injury. *See, e.g., Hawaii v. Standard Oil Co.*, 405 U.S. 251, 260, 92 S.Ct. 885, 890, 31 L.Ed.2d 184 (1972); *Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100, 130, 89 S.Ct. 1562, 1580, 23 L.Ed.2d 129 (1969); *Cia. Petrolera Caribe, Inc. v. Arco Caribbean, Inc.*, 754 F.2d 404, 407-08 (1st Cir. 1985). The traditional elements that a moving party must show for injunctive relief are: 1) irreparable harm to the Plaintiff if the injunction is not granted, 2)

inadequacy of a legal remedy, 3) that the public interest will not be adversely affected by granting the injunction; 4) that the harm to Plaintiff outweighs any harm to the Defendant by granting the injunction. But in order to prevail, Plaintiff must "demonstrate a significant threat of injury from an impending violation of the antitrust laws." *See id.* 395 U.S. at 130, 89 S.Ct. at 1580. Plaintiff need only show a threat of injury not an actual injury. *See Zenith Radio Corp.*, 395 U.S. at 130, 89 S.Ct. at 1580; *Cia. Petrolera Caribe, Inc.*, 754 F.2d at 407-08.

Plaintiffs have failed to show that adverse selection, the prudent buyer policy, or HealthMate have threatened loss or damage to their business or property because of violations of the antitrust laws for the reasons heretofore stated. Therefore, Plaintiffs' motion for a permanent injunction against prudent buyer policy and HealthMate is denied.

With respect to the Defendant's counterclaim for injunctive relief, it is premature. There is no evidence that the Plaintiff-Intervenors or their officers, directors, agents, or employees engaged in any illegal practice. Furthermore, there is no evidence that the Physicians and Surgeon Association of Rhode Island negotiated or attempted to negotiate collectively with Blue Cross concerning physicians' fees. Thus, Defendant's motion for a permanent injunction against the Plaintiff-Intervenors is denied.

DECLARATORY RELIEF

Plaintiffs also seek a declaratory judgment against the alleged acts which violate the Sherman Act. Defendant seeks a declaratory judgment against the Plaintiff-Intervenors from collectively negotiating fees to be paid by Blue Cross. The nature of the parties' claims is equitable. In light of the Court's previous ruling on the equitable claims, the Court denies declaratory relief to Plaintiffs and Defendant.

CONCLUSION

Defendant's motion for judgment notwithstanding the verdict is granted on both the antitrust claims and the interference with contractual relationships claims. Defendant's motion for a new trial is granted on the claims of intentional interference with contractual relationships. Plaintiffs' motion for additur is denied because there is no antitrust violation. Plaintiffs' motion for a permanent injunction against the prudent buyer program and HealthMate is denied because Plaintiffs' failure to show a prospective injury. The Defendant's counterclaim against the Plaintiff-Intervenors is denied because it is premature.

APPENDIX D

UNITED STATES DISTRICT COURT
JUDICIAL DISTRICT OF RHODE ISLAND

Case Number 86-0598B

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al*

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND

JUDGMENT IN A CIVIL CASE

☐ Jury Verdict. This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

☒ Decision by Court. This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED that judgment is entered for the defendant, Blue Cross and Blue Shield of Rhode Island in accordance with the Court's opinion dated July 27, 1988.

Date July 28, 1988

/s/ Lorraine Kizer
(By Deputy Clerk)

UNITED STATES DISTRICT COURT
DISTRICT OF RHODE ISLAND

Case Number 86-0598 B

OCEAN STATE PHYSICIANS HEALTH PLAN, INC.

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND

VERDICT

WE, THE JURY, FIND:

I. as to plaintiffs' Sec. 2 claim; Guilty. No Damages

II. as to plaintiffs' claim of interference with contractual relationship; Guilty

Compensatory Damages	$947,000.00
Punitive Damages	250,000.00

/s/ Lucien E Watters
Foreperson's Signature

24 October 1987
Date

UNITED STATES DISTRICT COURT
DISTRICT OF RHODE ISLAND

Case Number: 86-8598 B

ANTHONY J. KAZLAUSKAS and JEFFREY C. WINTERS on behalf of physicians who had contracts with OCEAN STATE PHYICIANS HEALTH PLAN, INC. on APRIL 2, 1987

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND

VERDICT

WE, THE JURY, FIND:

I. as to plaintiff's Sec. 2 claim; Guilty. No [illegible]

II. as to plaintiffs' claim for interference with contractual relationships; Guilty

Compensatory Damages $1,776,437.00

/s/ Lucien E Watters
Foreperson's Signature

24 October 1987
Date

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

No. 88-1851

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Plaintiffs, Appellants,

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND,
Defendant, Appellee.

Before

Campbell, *Chief Judge,*

Bownes, Breyer, Torruella, Selya* *Circuit Judges,*
and Caffrey** *Senior District Judge.*

ORDER OF COURT

Entered: September 25, 1989

The panel of judges that rendered the decision in this case having voted to deny the petition for rehearing and the suggestion for the holding of a rehearing en banc having been carefully considered by the judges of the Court in regular active service and a majority of said

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* Judge Selya has recused himself.

** Of the District of Massachusetts, sitting by designation.

judges not having voted to order that the appeal be heard or reheard by the Court en banc,

It is ordered that the petition for rehearing and the suggestion for rehearing en banc be denied.

By the Court:

/s/ Francis P. Scigliano
Clerk

[cc: Messrs. Gerson and Snow]

APPENDIX F

[Transcript Exchange Between Counsel
and District Court Judge 10/9/87]

* * * *

FRIDAY, OCTOBER 9, 1987

[2] . . . (JURY ABSENT)

THE COURT: At the close of the plaintiffs' case the defendant, Blue Cross/Blue Shield, has moved for a directed verdict. This action is brought by a number of plaintiffs: (1) A provider of health insurance called Ocean State; two individual physicians employed by Ocean State, a class of physicians who are described as being, having contracts with Ocean State, and a number of individual physicians.

A little history is helpful here. The genesis of today's problem started in the 1930's when apparently there was some difficulty both on the part of individuals to pay health care costs and difficulties on the part of providers, hospitals and physicians, to obtain payment for health care costs. One conjurs up the vision of the physician being paid with chickens and that sort of thing, which those who lived in that period of time know to be accurate. Indeed, some physicians didn't get chickens or anything else, they didn't get paid. So that Blue Cross and Blue Shield began some decades ago in an atmosphere that was intended to provide a means whereby people, whereby health care costs could be spread so that people could afford the costs of health care. and so those that provided the health care would be paid. A [3] commendable effort which as the years have gone by has turned from the doctor's best friend to, from what one hears from the witness stand, to be the doctor's enemy over that period of time. In the 1970's there emerged a health care system, provider system, that was able to better control the use of health care facilities and personnel by imposing a kind

of physical responsibility on those who were paying the costs and getting the benefits out of it, that is, that the so-called HMO in which, of two types, one in which the medical doctors who were providing the services were actually employees and on a salary base, and the type where the fees to a large extent were regulated by the HMO with respect to participating physicians of such a type as the latter type as Ocean State.

Another of the actors who are present in this proceeding is an organization known as RIGHA which is a type of organization where the physicians are generally employees of the organization and paid on a salary basis. Everybody seems to agree that this latter development is the wave of the future, the so-called indemnity plan, such as Blue Cross/Blue Shield have at best a limited life in terms of what is going to happen and what is happening and what will happen in the future. Against this background is a situation that might be described as the events of the [4] summer of '86 in which both Ocean State and Blue Cross found themselves in some financial straits which required some improvement. Ocean State apparently accomplished this by a change in management and by other changes a little later on after summer such as the so-called SIPS program in which there is a pool of money established for certain specialties and in which the specialists may dip in the pool until the pool runs dry at which point they get no more for their services. In July of that year there was some rather intensive, apparently, competition for one group of employees who were employed by the State of Rhode Island, approximately fifteen thousand people. That process involved a bidding process in which Blue Cross and Ocean State bid and in which for the first time emerged a plan sponsored by Blue Cross which was something of a twin of the Ocean State Plan. That plan being called HealthMate. That was for the first time offered to the state employees at that period of time. To me the somewhat staggering financial losses that Blue

Cross was suffering at that time there were a number of things, a number of programs undertaken which all came together pretty much at the same time in addition to HealthMate. Two of the other efforts were a plan called Prudent Buyer, and the third called Adverse Selection.

In and about 1982 Blue Cross and Blue Shield merged [5] and, as I indicated, RIGHA came along in 1970. RIGHA, for a substantial period of time, purchased its hospital care from Blue Cross/Blue Shield providing its own medical services but arranging for the payment of hospital costs through Blue Cross. Blue Cross, has been indicated, was the first one on the block and achieved some substantial success in terms of enrollment. Indeed, probably was the only one on the block for a long period of time. As a result today enjoys what certainly has to be characterized as the dominant share of the Rhode Island health care provider market. Blue Cross was able to negotiate favorable arrangements with all of the hospitals in the State of Rhode Island such that it enjoyed a substantial discount. In exchange for this it did a number of things that were certainly pleasing to the hospitals. It guaranteed a cash flow. It provided the money up front and it did a number of other things.

The plaintiffs in this case make essentially three claims. (1) That the defendants have violated Section 1 of the Sherman Act in two ways, a conspiracy between RIGHA and Blue Cross, and an illegal merger in October of 1982; that the defendant has violated Section 2 of the Sherman Act in that it has used market power as a monopolist in an anticompetitive fashion, and (3) that the defendant has tortiously interferred with the contracts, not of those physicians who [6] left Ocean State and had contracts with Ocean State, but of the contracts of those physicians who remained with Ocean State.

Section 1 of the Sherman Act provides that every contract, combination in the form of trusts or otherwise or conspiracy in restraint of trade or commerce among the several states or with foreign nations are declared to be

illegal. Through the years that language has come to mean that every unreasonable restraint is illegal although the word "unreasonable" doesn't appear in the language of the statute. Section 2 provides that it shall be an offense to monopolize or attempt to monopolize or combine or conspire with any other person or persons to monopolize any part of the trade or commerce among the several states. In this case it is conceded that Blue Cross' market share was not achieved through illegal means in terms of the monopolization charge. But that what has happened here is that the combination of the policies adopted by Blue Cross to meet the threat of competition from Ocean State results in an anti-competitive package which triggers the necessary response under Section 2 of the Sherman Act. At this point we're concerned only with the question of damages. The Court will later address the issue of the application for equitable relief.

With respect to the merger of Blue Cross and Blue Shield, [7] that occurred in October 1982 at a time when Ocean State was a gleam in its progenitor's eyes. On a motion for a new trial the Court is required to approach the evidence from the standpoint most favorable to the party against whom the motion is made.

Did I say "new trial"?

MR. GEARSON: Yes, Your Honor, you did.

THE COURT: On motion for directed verdict. It is not required, however, to defer the direction of a verdict because there is little bit or a scintilla of evidence. There must be some substantial evidence that supports the claim, evidence from which reasonable jurors could come to the urged conclusion, that is, that there's a violation of Sections 1 or 2 or the tort of interference with advantageous relationships. There is a total lack of any evidence in this case, a total lack of evidence, that the Blue Cross/Blue Shield merger had any anti-competitive effect on Ocean State, or indeed any of the other plaintiffs in this suit. The argument is made that the combination of RIGHA and Blue Cross was a conspiracy which

had an effect with respect to the hospitals that each dealt with, that it had the effect of causing the hospitals to make confessions that were not made to others. The record is clear, however, that [8] there were concessions made to others, not to the same extent, but there were concessions made by hospitals. Additionally this is a suit for damages and neither Ocean State nor any of the physicians involved in this case can point to any instance in which they have been damaged in any way, in any fashion by the agreement between Blue Cross and RIGHA or by the agreement between Blue Cross and the hospitals. If there was a victim, if there was a conspiracy and there was a victim, the victim was the hospital. Not Ocean State and not any of the doctors involved. That seems perfectly clear when one applies the principles that were applied by the First Circuit in *Cartel against Blue Shield* reported at *749 F.2d. 922.*

So that as to the plaintiffs' Section 1 claim, the defendant's motion for a directed verdict is granted.

Now, again, there must be some issue for the jury to decide in order that the plaintiffs may avoid a directed verdict on the Section 2 claim. At this point I'm not permitted to resolve any inferences that might arise from the circumstances. It seems to me I'm required to permit the jury to decide at this point whether or not the combination of weapons that Blue Cross/Blue Shield put together in its competitive package had an anti-competitive effect, that is, whether these, the matter of health, the combination of HealthMate and Adverse Selection and the [9] Prudent Buyer policy. At this point at least it seems to me that it raises a question which more properly should be determined by a jury. With respect then to Ocean State and its Section 2 claim that motion for directed verdict is denied.

Let's take the physicians' union. The physicians' union admitted that it has no claim for damages here. So the motion is directed as to all three issues on the physicians' union.

With respect to the claims of the individual physicians and Section 2 there are a number of complications. Not the least of which is that except for one they are all employees of professional corporations. Those professional corporations are of significance. They are of substantial significance when it comes to tax considerations. They are of substantial significance when it comes to malpractice claims. They are of substantial entities when it comes to who buys a new car. They are real existing entities and they are the entities that bill Blue Cross or Ocean State or anybody else and then they pay the doctors who work for them even though the doctors may themselves own a hundred percent of the stock of the corporation. They are separate and distinct from the corporation. Here those entities have not been made party nor have there been any effort to make them parties to this litigation. What has been done [10] is that purported assignments of the professional corporation's claims have been made to the individually named plaintiff doctors, assignment of claims for damages and for injunctive relief.

The plaintiffs argue that this is a perfectly appropriate process, that this has been done before and has been approved. An examination of the authorities cited in support of that demonstrates that what has been approved in the past has been an assignment by a member of an association to the association where there is a coordination of interest between the individual and the association to press forward on an anti-trust claims. The fruitgrowers all got together and the pharmacists all got together and they assigned their claim for damages and equitable relief to the fruitgrowers association or to the pharmacists association, trade association. That's not what happened here. For instance, there has been no assignment or purported assignment to the physicians' union. What has happened is the corporation has turned around and assigned its claim to an individual. It seems to me that makes quite a difference, that it raises some

serious question as to whether or not there's any validity to that, whether or not that's so. And this is an effort to, without applying to the Court, to make parties to the litigation corporations that had never been made parties to litigations. It's an effort to amend the [11] complaint to add parties, to back into this sort of situation. It seems to me that for that reason it must fail.

Additionally there is no real evidence of damages to these physicians arising out of any of these so-called anti-competitive acts. There's no evidence that any physician lost income, none whatsover. There's evidence that money was withheld, but there is also no argument that the withholding was illegal. No one has remotely, except for a medical doctor, no one has remotely suggested that Blue Cross didn't have the right to withhold that money under its contract and no argument was made that that's the case. So that apart from the question of whether the corporations are here there is nothing really for a jury to award damages to the physicians in this case. So that with respect to the individual physicians on the Section 2 claim the motion is—I might say on the Section 1 claim it's granted as to all of the plaintiffs. Section 2, it's denied as to Ocean State, granted as to the individually-named physicians.

A rather unique argument is made with respect to the members of the class who are physicians contracted with Ocean State that because other physicians resigned from Ocean State allegedly due to this anti-competitive package, Ocean State was drained of some resources it [12] otherwise would have been paid to those who remained contracted to Ocean State. That it seems to me is a little attenuated but at this point I am not prepared to say that it's not something the jury shouldn't decide.

Now, much of what I've said with respect to the physicians can be applied to the third issue that is here, that is, this contractual, interference with advantageous relationships. That motion is denied with repect to Ocean State, and it's denied with respect to the class of those

who are contracted with Ocean State and granted with respect to the individual physicians. All parties may have exceptions.

MR. QUINLAN: May we just ask for clarification on one point.

THE COURT: Yes.

MR. QUINLAN: On Dr. Erinakes, he is not a professional corporation.

THE COURT: No damages, no damages. You may not agree with me, but that's the ruling, all right?

MR. QUINLAN: Yes, Your Honor.

THE COURT: Are you ready to go?

MR. SNOW: Yes, Your Honor.

MR. GEARSON: Your Honor, I believe there's a matter that Mr. Lynch would like to . . .

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